

7955

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Villa Julie</u>		d. STREET ADDRESS <u>Villa Julie- Valley Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Sister Marie Rita (Ahern)</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 19, 1876</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR: Months <u>79</u> Days <u>79</u> Hours <u>79</u> Min. <u>79</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JAMES Ahern</u>		14. MOTHER'S MAIDEN NAME <u>Johanna Ahern</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT <u>Sister Marie Dolores</u>		Address <u>Villa Julie</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Renal Vascular disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>old age.</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 1956, to <u>Aug 6</u> , 1956, that I last saw the deceased alive on <u>Aug 4</u> , 1956, and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold H Burns</u>		DATE SIGNED <u>Aug 7, 56</u>	
PHYSICIAN'S NAME (Type) <u>Harold H. Burns</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-8-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Convent Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Ilchester Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fasley Funeral Home - Antomville, Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 10 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Mark Gray</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

DATE OF DEATH

DECEASED

100-100000

BUREAU V. S.

AUG 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07920

7956

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE St. Hosp.				d. STREET ADDRESS 201 Summit		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOUIS Middle William Last Alberts				4. DATE OF DEATH Month 8 Day 11 Year 1956			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-18-1904	
				9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) truck driver				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Peter Alberts				14. MOTHER'S MAIDEN NAME Anna Rinas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 211-051-3422			
				17. INFORMANT HOSPITAL RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Bronchopneumonia DUE TO 237X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tumor of left temporal lobe DUE TO type to be determined (c) ?mas.							INTERVAL BETWEEN ONSET AND DEATH 102 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 8/8 , 1956, to 8/11 , 1956, that I last saw the deceased alive on 8/11 , 1956, and that death occurred at 8:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ellis S. Margherita				ADDRESS (Street, city or town, state) Glenburnie, Md.			
PHYSICIAN'S NAME (Type)				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 16/56		22c. NAME OF CEMETERY OR CREMATORY Glen Haven		22d. LOCATION (City, town, or county) (State) Glenburnie Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry J. Wilk				ADDRESS 4101 Edmonson		24a. REC'D BY REGISTRAR DATE 8/12/56	
				24b. REGISTRAR'S SIGNATURE J. E. Harry			

CERTIFICATE OF DEATH

1. NAME OF DECEASED Peter Albert		2. SEX Male		3. AGE 4-10-1951	
4. DATE OF DEATH 11-11-1951		5. TIME OF DEATH 11:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart failure		8. DISEASE OR INJURY Myocardial infarction		9. MANNER OF DEATH Natural	
10. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		11. SIGNATURE OF WITNESSES Dr. J. H. Smith		12. SIGNATURE OF DECEASED Peter Albert	
13. SIGNATURE OF REGISTRAR John Doe		14. SIGNATURE OF CLERK John Doe		15. SIGNATURE OF DECEASED Peter Albert	
16. SIGNATURE OF DECEASED Peter Albert		17. SIGNATURE OF DECEASED Peter Albert		18. SIGNATURE OF DECEASED Peter Albert	
19. SIGNATURE OF DECEASED Peter Albert		20. SIGNATURE OF DECEASED Peter Albert		21. SIGNATURE OF DECEASED Peter Albert	
22. SIGNATURE OF DECEASED Peter Albert		23. SIGNATURE OF DECEASED Peter Albert		24. SIGNATURE OF DECEASED Peter Albert	
25. SIGNATURE OF DECEASED Peter Albert		26. SIGNATURE OF DECEASED Peter Albert		27. SIGNATURE OF DECEASED Peter Albert	
28. SIGNATURE OF DECEASED Peter Albert		29. SIGNATURE OF DECEASED Peter Albert		30. SIGNATURE OF DECEASED Peter Albert	
31. SIGNATURE OF DECEASED Peter Albert		32. SIGNATURE OF DECEASED Peter Albert		33. SIGNATURE OF DECEASED Peter Albert	
34. SIGNATURE OF DECEASED Peter Albert		35. SIGNATURE OF DECEASED Peter Albert		36. SIGNATURE OF DECEASED Peter Albert	
37. SIGNATURE OF DECEASED Peter Albert		38. SIGNATURE OF DECEASED Peter Albert		39. SIGNATURE OF DECEASED Peter Albert	
40. SIGNATURE OF DECEASED Peter Albert		41. SIGNATURE OF DECEASED Peter Albert		42. SIGNATURE OF DECEASED Peter Albert	
43. SIGNATURE OF DECEASED Peter Albert		44. SIGNATURE OF DECEASED Peter Albert		45. SIGNATURE OF DECEASED Peter Albert	
46. SIGNATURE OF DECEASED Peter Albert		47. SIGNATURE OF DECEASED Peter Albert		48. SIGNATURE OF DECEASED Peter Albert	
49. SIGNATURE OF DECEASED Peter Albert		50. SIGNATURE OF DECEASED Peter Albert		51. SIGNATURE OF DECEASED Peter Albert	
52. SIGNATURE OF DECEASED Peter Albert		53. SIGNATURE OF DECEASED Peter Albert		54. SIGNATURE OF DECEASED Peter Albert	
55. SIGNATURE OF DECEASED Peter Albert		56. SIGNATURE OF DECEASED Peter Albert		57. SIGNATURE OF DECEASED Peter Albert	
58. SIGNATURE OF DECEASED Peter Albert		59. SIGNATURE OF DECEASED Peter Albert		60. SIGNATURE OF DECEASED Peter Albert	
61. SIGNATURE OF DECEASED Peter Albert		62. SIGNATURE OF DECEASED Peter Albert		63. SIGNATURE OF DECEASED Peter Albert	
64. SIGNATURE OF DECEASED Peter Albert		65. SIGNATURE OF DECEASED Peter Albert		66. SIGNATURE OF DECEASED Peter Albert	
67. SIGNATURE OF DECEASED Peter Albert		68. SIGNATURE OF DECEASED Peter Albert		69. SIGNATURE OF DECEASED Peter Albert	
70. SIGNATURE OF DECEASED Peter Albert		71. SIGNATURE OF DECEASED Peter Albert		72. SIGNATURE OF DECEASED Peter Albert	
73. SIGNATURE OF DECEASED Peter Albert		74. SIGNATURE OF DECEASED Peter Albert		75. SIGNATURE OF DECEASED Peter Albert	
76. SIGNATURE OF DECEASED Peter Albert		77. SIGNATURE OF DECEASED Peter Albert		78. SIGNATURE OF DECEASED Peter Albert	
79. SIGNATURE OF DECEASED Peter Albert		80. SIGNATURE OF DECEASED Peter Albert		81. SIGNATURE OF DECEASED Peter Albert	
82. SIGNATURE OF DECEASED Peter Albert		83. SIGNATURE OF DECEASED Peter Albert		84. SIGNATURE OF DECEASED Peter Albert	
85. SIGNATURE OF DECEASED Peter Albert		86. SIGNATURE OF DECEASED Peter Albert		87. SIGNATURE OF DECEASED Peter Albert	
88. SIGNATURE OF DECEASED Peter Albert		89. SIGNATURE OF DECEASED Peter Albert		90. SIGNATURE OF DECEASED Peter Albert	
91. SIGNATURE OF DECEASED Peter Albert		92. SIGNATURE OF DECEASED Peter Albert		93. SIGNATURE OF DECEASED Peter Albert	
94. SIGNATURE OF DECEASED Peter Albert		95. SIGNATURE OF DECEASED Peter Albert		96. SIGNATURE OF DECEASED Peter Albert	
97. SIGNATURE OF DECEASED Peter Albert		98. SIGNATURE OF DECEASED Peter Albert		99. SIGNATURE OF DECEASED Peter Albert	
100. SIGNATURE OF DECEASED Peter Albert		101. SIGNATURE OF DECEASED Peter Albert		102. SIGNATURE OF DECEASED Peter Albert	

RECEIVED
AUG 14 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7957

CERTIFICATE OF DEATH

07921

Reg. Dist. No.

40

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jork</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Sunshine Avenue</i>		d. STREET ADDRESS <i>Sunshine Avenue</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Eileen Mary Armstrong</i>		4. DATE OF DEATH Month Day Year <i>August 18th 1956</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 10, 1910</i>
9. AGE (In years last birthday) <i>46</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George R. Webster</i>		14. MOTHER'S MAIDEN NAME <i>Florence B. Bramble</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Rev. Robert E. Armstrong, Sunshine Ave.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of Colon</i> <i>153X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of Colon</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <i>5 months</i> <i>1 1/2 years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 1, 1954</i> to <i>Aug 18, 1956</i> that I last saw the deceased alive on <i>Aug 18, 1956</i> , and that death occurred at <i>3 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Harry J. Kane</i> M.D. <i>2607 E. Pratt St. Baltimore, Md.</i>		DATE SIGNED <i>8-20-56</i>	
PHYSICIAN'S NAME (Type) <i>HARRY F. KANE</i>		<i>Baltimore, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/22/1956</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>AUG 21 1956</i> 24b. REGISTRAR'S SIGNATURE <i>Dr. Walter H. Bennett</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
OCCUPATION		EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT		BUILD	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF JUDGE	

BUREAU V. S.

AUG 22 1956

RECEIVED

7958

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3001-4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>6 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5514 Wayne Avenue, Baltimore City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>5514 Wayne Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES B. BAILEY</u>				4. DATE OF DEATH Month Day Year <u>August 15 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 17, 1907</u>		9. AGE (In years last birthday) yrs. <u>49</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Itinerant Self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Staunton, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles B. Bailey</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Baber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION, ACUTE</u> DUE TO (b) <u>PULMONARY INFARCTION</u> DUE TO <u>THROMBOPHLEBITIS</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>3 MONTHS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>August 9, 1956</u> , to <u>August 15, 1956</u> , and that death occurred at <u>5:05 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>W. J. Pljnowski</u> M.D. <u>Veterans Administration Hospital 8/16/56</u> PHYSICIAN'S NAME (Type) <u>WALTER J. PLJNOWSKI, M.D.</u> <u>Fort Howard, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>8-16-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Thorn Road Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Staunton, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc. 6009 Harford Rd. Balto. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>23 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Lawrence L. Larley</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 23 1956

BUREAU V. 8

RECEIVED		AUG 23 1956		BUREAU V. 8	
MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD					
CERTIFICATE OF DEATH					
1. NAME OF DECEASED					
2. SEX					
3. AGE					
4. DATE OF BIRTH					
5. PLACE OF BIRTH					
6. OCCUPATION					
7. CAUSE OF DEATH					
8. MANNER OF DEATH					
9. SIGNATURE OF DECEASED					
10. SIGNATURE OF WITNESSES					
11. SIGNATURE OF DECEASED					
12. SIGNATURE OF WITNESSES					
13. SIGNATURE OF DECEASED					
14. SIGNATURE OF WITNESSES					
15. SIGNATURE OF DECEASED					
16. SIGNATURE OF WITNESSES					
17. SIGNATURE OF DECEASED					
18. SIGNATURE OF WITNESSES					
19. SIGNATURE OF DECEASED					
20. SIGNATURE OF WITNESSES					
21. SIGNATURE OF DECEASED					
22. SIGNATURE OF WITNESSES					
23. SIGNATURE OF DECEASED					
24. SIGNATURE OF WITNESSES					
25. SIGNATURE OF DECEASED					
26. SIGNATURE OF WITNESSES					
27. SIGNATURE OF DECEASED					
28. SIGNATURE OF WITNESSES					
29. SIGNATURE OF DECEASED					
30. SIGNATURE OF WITNESSES					
31. SIGNATURE OF DECEASED					
32. SIGNATURE OF WITNESSES					
33. SIGNATURE OF DECEASED					
34. SIGNATURE OF WITNESSES					
35. SIGNATURE OF DECEASED					
36. SIGNATURE OF WITNESSES					
37. SIGNATURE OF DECEASED					
38. SIGNATURE OF WITNESSES					
39. SIGNATURE OF DECEASED					
40. SIGNATURE OF WITNESSES					
41. SIGNATURE OF DECEASED					
42. SIGNATURE OF WITNESSES					
43. SIGNATURE OF DECEASED					
44. SIGNATURE OF WITNESSES					
45. SIGNATURE OF DECEASED					
46. SIGNATURE OF WITNESSES					
47. SIGNATURE OF DECEASED					
48. SIGNATURE OF WITNESSES					
49. SIGNATURE OF DECEASED					
50. SIGNATURE OF WITNESSES					
51. SIGNATURE OF DECEASED					
52. SIGNATURE OF WITNESSES					
53. SIGNATURE OF DECEASED					
54. SIGNATURE OF WITNESSES					
55. SIGNATURE OF DECEASED					
56. SIGNATURE OF WITNESSES					
57. SIGNATURE OF DECEASED					
58. SIGNATURE OF WITNESSES					
59. SIGNATURE OF DECEASED					
60. SIGNATURE OF WITNESSES					
61. SIGNATURE OF DECEASED					
62. SIGNATURE OF WITNESSES					
63. SIGNATURE OF DECEASED					
64. SIGNATURE OF WITNESSES					
65. SIGNATURE OF DECEASED					
66. SIGNATURE OF WITNESSES					
67. SIGNATURE OF DECEASED					
68. SIGNATURE OF WITNESSES					
69. SIGNATURE OF DECEASED					
70. SIGNATURE OF WITNESSES					
71. SIGNATURE OF DECEASED					
72. SIGNATURE OF WITNESSES					
73. SIGNATURE OF DECEASED					
74. SIGNATURE OF WITNESSES					
75. SIGNATURE OF DECEASED					
76. SIGNATURE OF WITNESSES					
77. SIGNATURE OF DECEASED					
78. SIGNATURE OF WITNESSES					
79. SIGNATURE OF DECEASED					
80. SIGNATURE OF WITNESSES					
81. SIGNATURE OF DECEASED					
82. SIGNATURE OF WITNESSES					
83. SIGNATURE OF DECEASED					
84. SIGNATURE OF WITNESSES					
85. SIGNATURE OF DECEASED					
86. SIGNATURE OF WITNESSES					
87. SIGNATURE OF DECEASED					
88. SIGNATURE OF WITNESSES					
89. SIGNATURE OF DECEASED					
90. SIGNATURE OF WITNESSES					
91. SIGNATURE OF DECEASED					
92. SIGNATURE OF WITNESSES					
93. SIGNATURE OF DECEASED					
94. SIGNATURE OF WITNESSES					
95. SIGNATURE OF DECEASED					
96. SIGNATURE OF WITNESSES					
97. SIGNATURE OF DECEASED					
98. SIGNATURE OF WITNESSES					
99. SIGNATURE OF DECEASED					
100. SIGNATURE OF WITNESSES					

7959

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>506 Castle Drive</u>		d. STREET ADDRESS <u>506 Castle Drive - Balto. 12, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>BAKER</u> Last <u>BAKER</u>		4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17, 1884</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>14</u> Hours <u>14</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Casualty Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>A. S. County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Brown</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Miss Virginia H. Baker-506 Castle Drive #12</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC HEART DIS.</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>Indef</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thyroidism (Toxic Nodular goiter) - Cerebrovascular Thrombosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, <u>Aug</u> , Year, <u>1956</u> Hour <u>7</u> a.m. <u>18 Aug 1956</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>55</u> , to <u>18 Aug</u> , 19 <u>56</u> that I last saw the deceased alive on <u>18 Aug</u> , 19 <u>56</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B DeHoff</u>		DATE SIGNED <u>Loch Raven Shopping C</u>	
PHYSICIAN'S NAME (Type) <u>JOHN B DEHOFF</u>		ADDRESS (Street, city or town, state) <u>Baltimore 12 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/20/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker-Hons - North</u>		24. REC'D BY REGISTRAR <u>Aug 21 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956 21 AUG

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7960 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07924

Reg. Dist. No. **38**

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWSON</u>		c. LENGTH OF STAY IN 1b <u>70 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00331 HILLEN RD</u>			d. STREET ADDRESS <u>331 HILLEN RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>DORA</u> Middle <u>ELIZABETH</u> Last <u>BANKS</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>25</u> Year <u>1956</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-13-84</u>		9. AGE (In years last birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>UNKNOWN</u>		
14. MOTHER'S MAIDEN NAME <u>HARRIS</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>—</u>			17. INFORMANT Address <u>Chas. Banks 331 Hillen Rd. Towson</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.					
ACTUAL SIGNATURE <u>William A. Pillsbury</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>8/25/56</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>	
22d. LOCATION (City, town, or county) <u>Towson md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Chatman Jr.</u>			ADDRESS <u>1701 McCallister St. Balto. Md.</u>		
24a. REC'D BY REGISTRAR <u>DATE 8/28/56</u>		24b. REGISTRAR'S SIGNATURE <u>Mable C. Gray</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH-DEATH RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH	
SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	

BUREAU V. 2

JUG 28 1956

RECEIVED

07925

MARYLAND STATE DEPARTMENT OF HEALTH

7961

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>415 Pittsburg Ave</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>415 Pittsburg Ave</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Burns Station</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2</u>		STREET ADDRESS <u>Baltimore 22nd</u>	
3. NAME OF DECEASED (Type or Print) <u>Bettie Barber</u>		4. DATE OF DEATH (Month) <u>August</u> (Day) <u>17th</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>yes</u>	8. DATE OF BIRTH <u>January 3rd</u>
10a. USUAL OCCUPATION (Give kind of work done during most of lifetime, if even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday <u>51</u> yrs.
11. FATHER'S NAME <u>Daniel Grant</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. MOTHER'S MAIDEN NAME <u>Ella Cooper</u>		14. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Robert Barber 415 Pittsburg</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Thrombosis

Antecedent cause(s)

(b)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY

CITY OR TOWN

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 17th, 1956, to Aug 17th, 1956, that I last saw the deceasedalive on 17th August 1956 and that death occurred at 7 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

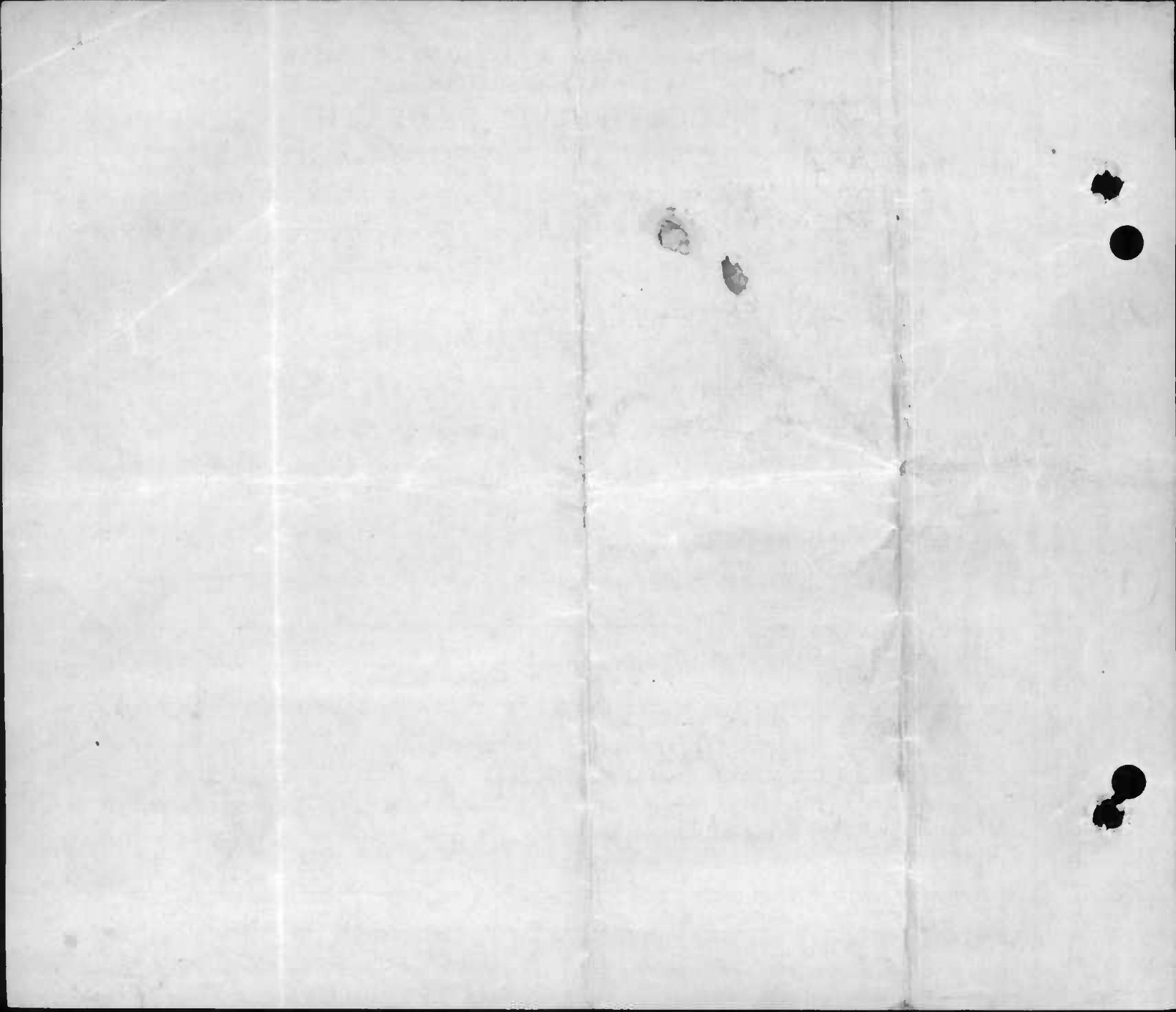
24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

7962

07926

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Golden Ring</u>			c. LENGTH OF STAY IN 1b <u>6 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Golden Ring</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6408 Kenwood Ave</u>				d. STREET ADDRESS <u>6408 Kenwood Ave</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Barr</u> Last <u>Barr</u>				4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 22-1902</u>	
9. AGE (In years lost birthday) <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Barr</u>				14. MOTHER'S MAIDEN NAME <u>Valeria Lorniller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>232-058528</u>		17. INFORMANT Address <u>Mrs Robert Barr 6408 Kenwood Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>40 min.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>53</u> , to <u>August</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug. 17</u> , 19 <u>56</u> , and that death occurred at <u>11:00p</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8019 Philadelphia Rd.</u> DATE SIGNED <u>8-21-56</u>							
ACTUAL SIGNATURE <u>James R. Mason</u> M.D.				24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>			
PHYSICIAN'S NAME (Type) <u>James R. Mason, M. D.</u>				24c. REC'D BY REGISTRAR <u>DATE 221956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Balto md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassalw Funeral Home 7401 Belair Rd</u>				24a. DATE <u>221956</u>			

CERTIFICATE OF DEATH

7002

Page One

Name of Deceased John W. Jones		Sex Male	
Date of Birth 1910		Age 42	
Place of Birth Baltimore, Md.		Race White	
Usual Residence 1234 Main St., Baltimore, Md.		Cause of Death Heart Disease	
Date of Death Aug 22, 1956		Time of Death 10:30 AM	
Place of Death Home		Physician Dr. J. H. Smith	
Manner of Death Natural		Certified by Dr. J. H. Smith	
Signature of Physician		Signature of Registrar	
Signature of Deceased		Signature of Next of Kin	
Signature of Burial Director		Signature of Funeral Home	
Signature of Coroner		Signature of Medical Examiner	
Signature of Health Officer		Signature of State Health Officer	

RECEIVED
AUG 22 - 1956
BUREAU V. S.

7963

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Stoneleigh</u>		c. LENGTH OF STAY IN 1b <u>16 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>614 Hatherleigh Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Columbus BASFORD</u>		4. DATE OF DEATH <u>Aug 17</u> 19 <u>56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28 1864</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life) even if retired) <u>Assistant Master B&O RR (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Basford</u>		14. MOTHER'S MAIDEN NAME <u>Loretta Wren</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Miss Edith M. Basford</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Coronary Insufficiency - Angine Pectoris</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>?</u> <u>1 wk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 17, 1950</u> to <u>Aug 17, 1956</u> , that I last saw the deceased alive on <u>Aug 17, 1956</u> , and that death occurred at <u>2:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert H. Silver</u>		ADDRESS (Street, city or town, state) <u>3105 N. Chader St. Balto.</u>	
PHYSICIAN'S NAME (Type) <u>R. H. Silver</u>		DATE SIGNED <u>Aug 18, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 20 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louden Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Jenkins & Son Co</u>		ADDRESS <u>4905 York Rd</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7964

CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 839 ARNCLIFF ROAD		d. STREET ADDRESS 839 ARNCLIFF ROAD	
3. NAME OF DECEASED (Type or print) WILLARD B. BENNETT		4. DATE OF DEATH AUGUST 6 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 18, 1915
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUDITOR		10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME RICHARD BENNETT		14. MOTHER'S MAIDEN NAME MAMMIE MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 235-12-2032	
17. INFORMANT JULIA P. BENNETT		Address 839 ARNCLIFF ROAD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Carcinoma of stomach DUE TO (c) with metastases		INTERVAL BETWEEN ONSET AND DEATH 1 wk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 55 , to 8/7 , 19 56 , that I last saw the deceased alive on 8/2 , 19 56 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Platt		ADDRESS (Street, city or town, state) 434 EASTERN AVE	
PHYSICIAN'S NAME (Type) J. PLATT		DATE SIGNED 8/7/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-9-56	
22c. NAME OF CEMETERY OR CREMATORY OAK LAWN		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE A. Christine Brudzinski		ADDRESS 1407 Eastern Ave	
24a. REC'D BY REGISTRAR 8/7/56		24b. REGISTRAR'S SIGNATURE Edith Hurley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~pages~~ pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 7965
 CERTIFICATE OF DEATH

07929

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore, Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) English Consul				c. LENGTH OF STAY IN 1b 12 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2737 Alderwood Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle Elizabeth Last Bergmann				4. DATE OF DEATH Month August Day 23 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 2, 1867	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John Bergmann				14. MOTHER'S MAIDEN NAME Margaret Goldenhouse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. N one		17. INFORMANT Margaret E. Golden 2737 Alderwood Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 mo. 20 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/23/56 , to 8/23/56 , 19____, that I last saw the deceased alive on 8/23/56 , 19____, and that death occurred at 10:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Chas. L. Ball				ADDRESS (Street, city or town, state) M.D. Linthicum		DATE SIGNED 8/23/56	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 25 1956		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE		22d. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE William C. Dine				ADDRESS 1217 ST. PAUL		24a. REC'D BY REGISTRAR AUG 24 1956	
24b. REGISTRAR'S SIGNATURE Dr. Geo. M. Kuehner							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
JAMES M. JONES		35		M		W		1956		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.		FILE NO.	
1921		BALTIMORE		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL		1000		1000		1000	
DATE OF DEATH		PLACE OF DEATH		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.		FILE NO.	
1956		BALTIMORE		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL		1000		1000		1000	
DATE OF DEATH		PLACE OF DEATH		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.		FILE NO.	
1956		BALTIMORE		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL		1000		1000		1000	

BUREAU V. 3

AUG 27 1956

RECEIVED

1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7966

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07940

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere				c. LENGTH OF STAY IN 1b Edgemere			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 23 Pope Lane				e. STREET ADDRESS 23 Pope Lane			
3. NAME OF DECEASED (Type or print) First GEORGIANNA Middle BERRYMAN Last				4. DATE OF DEATH AUG. Month 19 Day 1956 Year			
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1883	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rock Hall Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Warner				14. MOTHER'S MAIDEN NAME Nancy Banks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Josphine Berryman 614 N. Monroe St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 10 yrs
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JACK C COLLINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF 8/2/1956		22c. NAME OF CEMETERY OR CREMATORY W.F. Galtman Cem. Balto.		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Kate R. Williams				ADDRESS 322 N Schroeder St.		24a. REC'D BY REGISTRAR Aug 21 1956	
				24b. REGISTRAR'S SIGNATURE Wm. P. Kelly			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		PREVIOUS DEATHS	
1000 E. CALHOUN ST., BALTIMORE, MD.		CLOCK REPAIRER		HIGH SCHOOL		MARRIED		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		EXAMINER'S SIGNATURE	
AUG 22 1968		BALTIMORE, MD.		HEART DISEASE		NATURAL		100-100000		J. EARL RAY	

BUREAU V. 1

AUG 22 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09023

7945

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>DUNDALK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>65 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>66 KINSHIP RD</u>		d. STREET ADDRESS <u>66 KINSHIP RD</u>	
3. NAME OF DECEASED (Type or print) <u>AGNES</u> First Middle Last		4. DATE OF DEATH <u>AUG. 17</u> Month Day Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 16, 1867</u>
9. AGE (In years) <u>89</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Pilachowski</u>		14. MOTHER'S MAIDEN NAME <u>Susan Mrowczyn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Mary Burano</u>		Address <u>66 Kinship Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Occlusion</u> DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/21/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEM</u>		22d. LOCATION (City, town, or county) (State) <u>DUNDALK</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Maher</u>		24a. REC'D BY REGISTRAR <u>SEP 13 1956</u>	
ADDRESS <u>401 S. Chester</u>		24b. REGISTRAR'S SIGNATURE <u>Thos. P. Kelly</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TWO FOR ONE CERTIFICATE FILM G 205 - 10/18/56 - mb

BUREAU V. 2

SEP 13 1956

RECEIVED

M

MARYLAND STATE DEPARTMENT OF HEALTH

07932

2411 N. Charles Street, Baltimore

7967

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH - COUNTY <u>Balto.</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Eatonswill</u>		LENGTH OF STAY (in this place) <u>16 7/8</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>	
TOWN <u>Eatonswill</u>				TOWN <u>Balto</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in Pines Fasting Ave</u>				STREET ADDRESS (If rural, give location) <u>524 Edgewood Dr</u>	
3. NAME OF DECEASED (First) <u>Alice</u> (Middle) <u>B.</u> (Last) <u>Biemiller</u>		4. DATE OF DEATH (Month) <u>8</u> (Day) <u>16</u> (Year) <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>12-9-1880</u>		9. AGE last birthday <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ref. Secretary</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. md</u>		12. CITIZEN OF WHAT COUNTRY?		10b. KIND OF BUSINESS OR INDUSTRY <u>Ins. Co.</u>	
13. FATHER'S NAME <u>John Henry Biemiller</u>		14. MOTHER'S MAIDEN NAME <u>Caroline M. Preis</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>12-03-4588A</u>		17. INFORMANT AND ADDRESS <u>Edmundson</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X Immediate cause

(a) Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

6 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic Hypertensive Cardiovascular Disease

15 yr. (7)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?					

22. I hereby certify that I attended the deceased from 5-25, 1956, to 8-15, 1956, that I last saw the deceased alive on 8-15, 1956 and that death occurred at 10:50 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

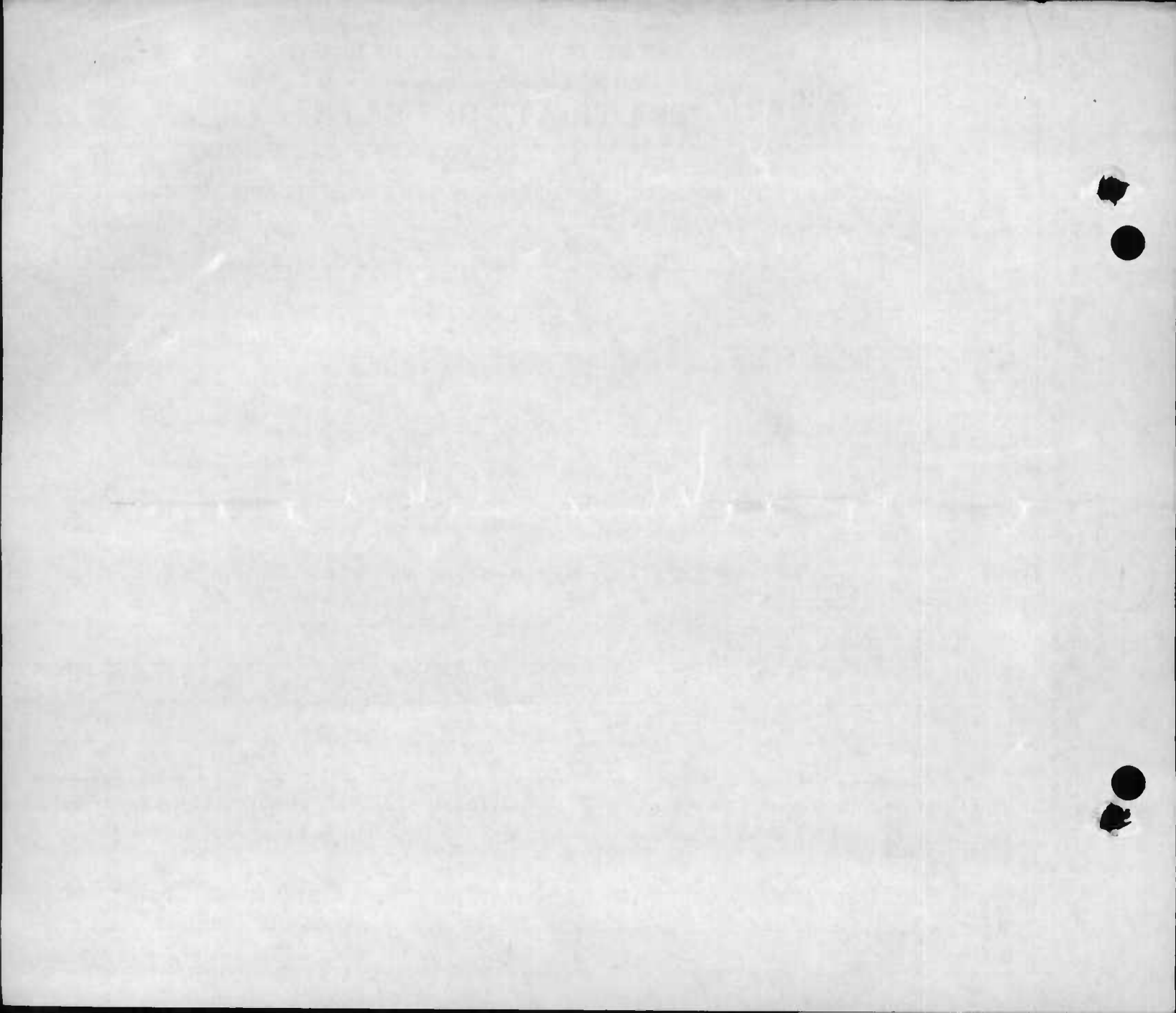
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Aug. 18, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Landown Cr</u>		LOCATION (City, town, or county) <u>Balto. md</u>		(State)	
DATE REC'D BY LOCAL REG. <u>8/16/56</u>		REGISTRAR'S SIGNATURE <u>Edmundson</u>		24. FUNERAL DIRECTOR <u>Harry H. Wight</u>		ADDRESS <u>4101 Edmondson</u>			

D.C.L.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07933

30

7968

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>md.</i>		COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		LENGTH OF STAY (in this place) <i>1 1/2 year</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		<i>3V51-4</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Paradise Home</i>				STREET ADDRESS (If rural give location) <i>504 Wingate Pl. - 10</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Clara</i> (Middle) <i>Martin</i> (Last) <i>Bingley</i>				(Month) <i>August</i> (Day) <i>18</i> (Year) <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>July 6, 1873</i>	9. AGE last birthday <i>83</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Bel Air md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Richard T. Martin</i>				14. MOTHER'S MAIDEN NAME <i>Ellen Holmead</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>Mr. M. C. Bingley Sr. Balto.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>422.1 Myocardial failure</i>				INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs</i>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <i>A.S. C.V.D.</i>				Unknown			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <i>Parkinson's Disease</i>				6 mos			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1-9, 1936</i> , to <i>8-17, 1956</i> , that I last saw the deceased alive on <i>8-16, 1956</i> , and that death occurred at <i>10:41 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Stephen Lee Mufson</i> M.D. <i>908 Frederick Rd Catonsville Md</i> DATE SIGNED <i>8-17-56</i> ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Aug 21-56</i>		NAME OF CEMETERY OR CREMATORY <i>Landon Park</i>		LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
24. REC'D BY REGISTRAR <i>21-1956</i>		REGISTRAR'S SIGNATURE <i>F. E. Harry</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Stewart Morn Co - Baltimore</i>		ADDRESS	

CERTIFICATE OF DEATH

7082

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

SEX

AGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

BUREAU V. S.

AUG 21 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7948 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07934
Reg. Dist. No. 42

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4604 College Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Otto William Birgel		4. DATE OF DEATH Month Day Year Aug. 9, 1956 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1898
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Maker		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co. Germany	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Adolph Birgel		14. MOTHER'S MAIDEN NAME Fredia	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-09-4614	
17. INFORMANT Address Grace I. Bergel, 4604 College Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Wound perforating gunshot chest left 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) self inflicted (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Glaucoma Bilateral Parkinsonism Hodgkin's Disease		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gunshot wound chest left 45 Cal. Automatic	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 8/9/56 12:00 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Arbutus 29 Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE W. E. Mc Grath		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) W. E. Mc Grath		DATE SIGNED 8/9/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-13-56	22c. NAME OF CEMETERY OR CREMATORY Landon Park	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR DATE 7-2-1956 24b. REGISTRAR'S SIGNATURE Dr. Geo. M. Kieffer	

BUREAU V. 8

13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

07935

2411 N. Charles Street, Baltimore

7969

CERTIFICATE OF DEATH

Item 7 FilmG203 9-14-56 et

Reg. Dist. No. 44

1. PLACE OF DEATH COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> TOWN <u>(19)</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 177 - A Avenue</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> TOWN <u>(19)</u> STREET ADDRESS (If rural, give location) <u>Box 177 Route #10</u>	
3. NAME OF DECEASED (Type or Print) <u>George Franklin Bitter</u>		4. DATE OF DEATH (Month) <u>August</u> (Day) <u>30</u> (Year) <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 9, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECH. REPAIR MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UTILITY</u>	9. AGE last birthday <u>67</u> yrs. If under 1 year: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Mins. <u>1</u>
13. FATHER'S NAME <u>George Bitter</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>212-05-3901</u>	
17. INFORMANT <u>William Kopp Bitter</u>		14. MOTHER'S MAIDEN NAME <u>Catharina (Hinkel)</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163X Immediate cause

(a) Carcinoma of Lung.

INTERVAL BETWEEN ONSET AND DEATH
2 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Hypertensive Arteriosclerotic Heart Disease

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 8/21, 1956, to 8/30, 1956, that I last saw the deceased alive on 8/30, 1956, and that death occurred at 4:45 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>9-3-56</u>	<u>Holy Redeemer</u>	<u>Baltimore, Md.</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>SEP 4 1956</u>	<u>Ransom L. Fisher</u>	<u>Walter Burke Bradley</u>	<u>Shirley</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 5 1956

BUREAU V. S.

7970

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hosp.</u>		d. STREET ADDRESS <u>Calvert Court</u>	
3. NAME OF DECEASED (Type or print) <u>Elsie</u> First <u>Blanchard</u> Middle <u>Blanchard</u> Last		4. DATE OF DEATH <u>August 4</u> Month <u>4</u> Day <u>1956</u> Year	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19. 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	11. BIRTHPLACE (State or foreign country) <u>La Salle, Ill.</u>
13. FATHER'S NAME <u>George Lane Blanchard</u>		14. MOTHER'S MAIDEN NAME <u>Fannie E. Snow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital records, Spring Grove S. H.</u>	
17. INFORMANT <u>Hospital records, Spring Grove S. H.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary insufficiency</u> DUE TO (c) <u>Hypertensive C.V.D. Left ventricular hypertrophy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7.5. 1956</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 7</u> , 19 <u>45</u> , to <u>August 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5.4</u> , 19 <u>56</u> , and that death occurred at <u>1:30</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gertrude J. Fleischmann M.D.</u>		ADDRESS (Street, city or town, state) <u>Spring Grove St. Hosp.</u> DATE SIGNED <u>8.4.56</u>	
PHYSICIAN'S NAME (Type) <u>GERTRUDE J. FLEISCHMANN</u>		SPRING GROVE ST. Hosp. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>8-6-56</u>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <u>Milton, Massachusetts</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barley Funeral Home</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>AUG 9 1956</u>		24b. REGISTRAR'S SIGNATURE <u>H. E. Gandy</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

09027

2411 N. Charles Street, Baltimore

9026

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>615 Pittsburg Ave</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Sunners Station</u>		LENGTH OF STAY (in this place) <u>6 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sunners Station</u>	
TOWN <u>Sunners Station</u>				STREET ADDRESS (If rural, give location) <u>615 Pittsburg Ave</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS					
3. NAME OF DECEASED (Type or Print)		(First) <u>Arthur</u> (Middle) <u>Blans</u> (Last) <u>Blans</u>		4. DATE OF DEATH (Month) <u>August</u> (Day) <u>29th</u> (Year) <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>February 12th 1881</u>	9. AGE last birthday <u>75 yrs.</u> If under 1 year: Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Waverly Blans</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>10-10-10</u>		17. INFORMANT AND ADDRESS <u>Elva Margaret Parks</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Broncho-pneumonia

INTERVAL BETWEEN ONSET AND DEATH

5 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Cerebral apoplexy10 days

(c)

Hypertensionunknown

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg, etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from August 15th to August 29th, that I last saw the deceased alive on August 29th, and that death occurred at 7:40 A.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

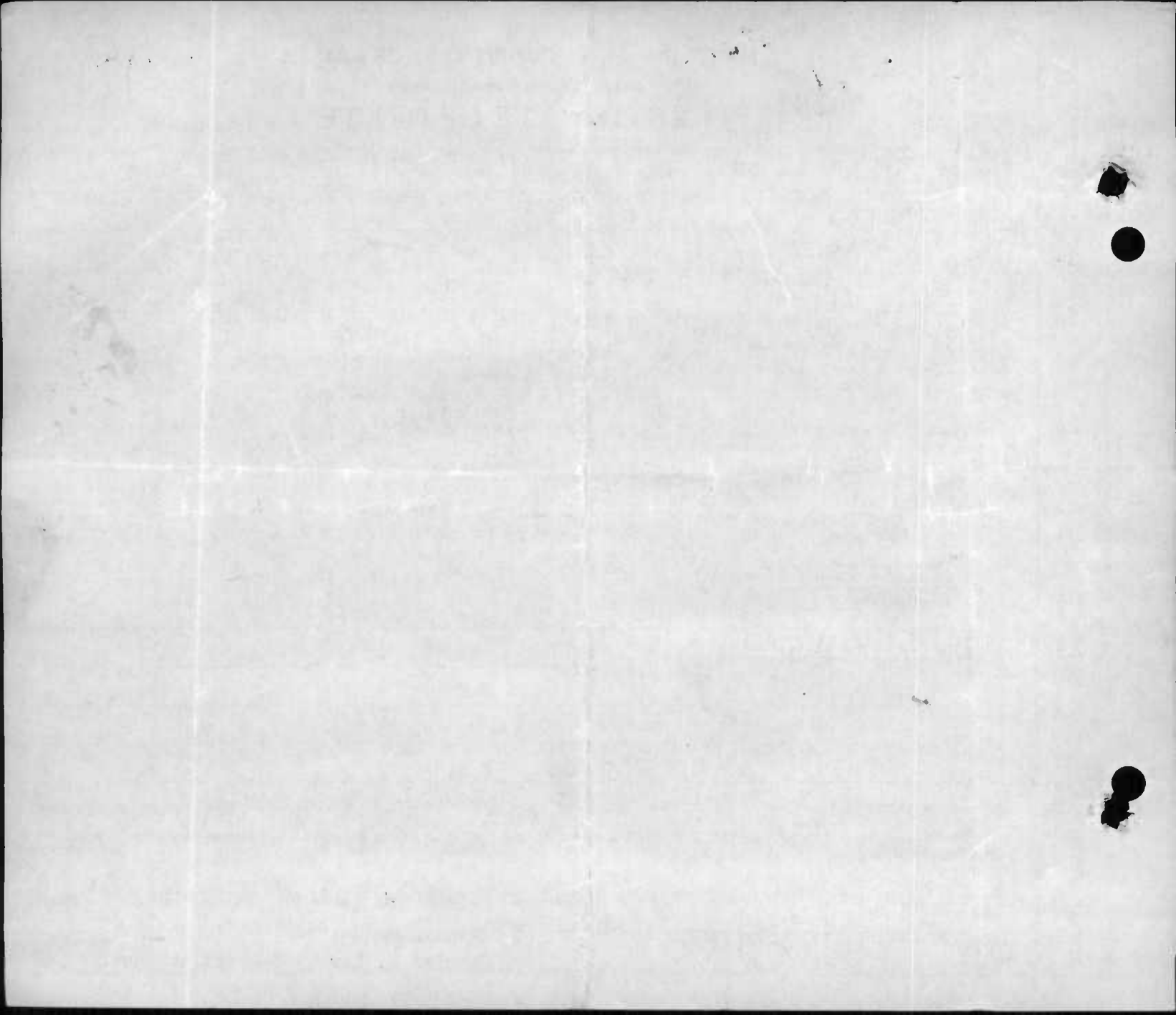
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>9/2/56</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>	LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>September 1st 1956</u>	REGISTRAR'S SIGNATURE <u>R.W.</u>	24. FUNERAL DIRECTOR <u>Charles R. Law</u>	ADDRESS <u>802 Madison Ave.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07937

7971

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville Rural			c. LENGTH OF STAY IN 1b 30 MRS.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gadd Road			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Helen First May Middle Bosley Last			4. DATE OF DEATH Month August Day 30 Year 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May, 14, 1913	9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Edgar Albright			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Robert W. Bosley Gadd Rd. Cockeysville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer, Cervix with Metastasis 171x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 30 , 19 56 to Aug 30 , 19 56 , and that death occurred at 11:45 AM from the causes and on the date stated above.					
ACTUAL SIGNATURE Clarence E. McWilliams M.D.		ADDRESS (Street, city or town, state) Reisterstown, Maryland Aug 30, 1956			
PHYSICIAN'S NAME (Type)		DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 3, 1956		22c. NAME OF CEMETERY OR CREMATORY Bosley Cemetery	
				22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons		ADDRESS Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE 9-2-56	
				24b. REGISTRAR'S SIGNATURE Mary B. Eline	

CERTIFICATE OF DEATH

1933

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased Robert V. Gossard		Sex Male		Age 30 Yrs.		Race White	
Place of Birth St. Louis, Mo.		Date of Birth Aug. 10, 1903		Place of Death Baltimore, Md.		Date of Death Aug. 25, 1933	
Cause of Death Heart Disease		Immediate Cause Myocardial Infarction		Underlying Cause Coronary Arteriosclerosis		Manner of Death Natural	
Physician's Signature Wm. H. Gossard		Physician's Title Physician		Physician's Address 1000 N. Broadway, Baltimore, Md.		Physician's Phone 1234	
Signature of Next of Kin Robert V. Gossard		Signature of Medical Examiner Wm. H. Gossard		Signature of Coroner Wm. H. Gossard		Signature of Registrar Wm. H. Gossard	
Name of Next of Kin Robert V. Gossard		Address of Next of Kin 1000 N. Broadway, Baltimore, Md.		Telephone of Next of Kin 1234		Occupation of Next of Kin Physician	
Name of Medical Examiner Wm. H. Gossard		Address of Medical Examiner 1000 N. Broadway, Baltimore, Md.		Telephone of Medical Examiner 1234		Occupation of Medical Examiner Physician	
Name of Coroner Wm. H. Gossard		Address of Coroner 1000 N. Broadway, Baltimore, Md.		Telephone of Coroner 1234		Occupation of Coroner Physician	
Name of Registrar Wm. H. Gossard		Address of Registrar 1000 N. Broadway, Baltimore, Md.		Telephone of Registrar 1234		Occupation of Registrar Physician	

BUREAU V. S

SEP 5 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7972

CERTIFICATE OF DEATH

Reg. Dist. No.

079303

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>REISTERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>REISTERSTOWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>434 MAIN ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCIS</u> <u>WEDNA</u> <u>BOWERSOX</u>		4. DATE OF DEATH Month Day Year <u>AUGUST</u> <u>14</u> <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 4 1879</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANCIS T. BOWERSOX</u>		14. MOTHER'S MAIDEN NAME <u>BERTHA E. WALTZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>188-03-0564</u>	
17. INFORMANT <u>Mrs EDNA WOLFE</u>		Address <u>434 MAIN ST REISTERSTOWN</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>THROMBOSIS, CORONARY</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>40 MIN.</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC. 2</u> , 1955, to <u>AUG 14</u> , 1956, that I last saw the deceased alive on <u>AUG 14</u> , 1956, and that death occurred at <u>2:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>CLARENCE E. McWilliams</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Reisterstown Maryland Aug 14/1956</u>	
PHYSICIAN'S NAME (Type) <u>CLARENCE E. McWilliams</u>		<u>REISTERSTOWN MARYLAND Aug 14/1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug-17-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pipe Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Uniontown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Berryman & Sons</u>		ADDRESS <u>Reisterstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 8-16-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary B. Elmer</u>	

BUREAU V.

AUG 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7973
CERTIFICATE OF DEATH

07939

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 9 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 3215 Lyndale Avenue	
3. NAME OF DECEASED (Type or print) CHARLES V. BRANNOCK		4. DATE OF DEATH Month August Day 10 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1885
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	
11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Franklin Brannock		14. MOTHER'S MAIDEN NAME Eona Wood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 216-07-8682	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH WITH METASTASIS 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease metastasis to liver Operation-5/21/56-University Hospital, Balto. Md.-Carcinoma Stomach with 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1, 1956 , to August 10, 1956 , and that death occurred at 5:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 8/10/56 ACTUAL SIGNATURE Francis G. Dickey M.D. PHYSICIAN'S NAME (Type) FRANCIS G. DICKEY, M.D., Chief, Medical Service			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/14/56	
22c. NAME OF CEMETERY OR CREMATORY Wood Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons - Balto 17, Md.		24a. REC'D BY REGISTRAR August 11 1956	
24b. REGISTRAR'S SIGNATURE Edw. Dawson L. Farley			

North and Pennsylvania Aves.
Wm. J. Tickner & Sons, Inc., Baltimore, Md.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

NAME		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
JAMES EARL RAY		APR 22, 1928		MOBILE, ALABAMA		ATTORNEY		HEART DISEASE		NATURAL	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
MEMPHIS, TENNESSEE		APR 4, 1968		MEMPHIS, TENNESSEE		ATTORNEY		HEART DISEASE		NATURAL	
SEX		AGE		RACE		RELIGION		EDUCATION		MARRIAGE	
MALE		39		WHITE		METHODIST		HIGH SCHOOL		MARRIED	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
JAMES EARL RAY		LUCILLE RAY		ATTORNEY		HOUSEWIFE		MOBILE, ALABAMA		MOBILE, ALABAMA	
DATE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
APR 1955		APR 4, 1968		MEMPHIS, TENNESSEE		ATTORNEY		HEART DISEASE		NATURAL	
SIGNATURE OF DECEASED		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	

BUREAU V. 2

AUG 13 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7974

CERTIFICATE OF DEATH

07940

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3629 Florida Rd.				d. STREET ADDRESS 3629 Florida Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LUTHER Middle DAVID Last BRILES				4. DATE OF DEATH Month Aug. Day 18, Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1895		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Head Janitor		10b. KIND OF BUSINESS OR INDUSTRY Md. State Emplmt		11. BIRTHPLACE (State or foreign country) N. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Hill Briles				14. MOTHER'S MAIDEN NAME A. Elizabeth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Mrs. Ora V. Briles - 3629 Florida Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Passive Degeneration of Kidneys 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 mos. 3 yrs 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis, Emphysema							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 9, 1953 to Aug 18, 1956 , that I last saw the deceased alive on July 30, 1956 , and that death occurred at 4:58 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Wesley Edel				ADDRESS (Street, city or town, state) 3403 Garrison Blvd Baltimore 15 Md			
PHYSICIAN'S NAME (Type) J. Wesley Edel				DATE SIGNED 8/24/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/21/56		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Vickner & Sons - Balto 17 Md				24. REC'D BY REGISTRAR DATE 8-23-1956		24b. REGISTRAR'S SIGNATURE Dr. Wm. E. Martin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7975
CERTIFICATE OF DEATH

07942-

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 27 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle E. Last BROWN		4. DATE OF DEATH Month August Day 11 Year 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/92
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butler		10b. KIND OF BUSINESS OR INDUSTRY Private Family	
11. BIRTHPLACE (State or foreign country) Catonsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Brown		14. MOTHER'S MAIDEN NAME Sarah Rawlings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 331x DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA, RIGHT LOWER LOBE INTERVAL BETWEEN ONSET AND DEATH 22 Days 1 Plus Month			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 15 , 19 56 , to August 11 , 19 56 , and that death occurred at 10:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fort Howard, Md. DATE SIGNED 8-12-56 ACTUAL SIGNATURE G. Edwards M.D. Fort Howard, Md. 8-12-56 PHYSICIAN'S NAME (Type) A. G. Edwards M.D. Fort Howard, Md. 8-12-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-15-56	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Mortuary, 802-04 Madison Ave., Baltimore, Maryland		24a. REC'D BY REGISTRAR 8/14/56	
24b. REGISTRAR'S SIGNATURE Dawson L. Farber			

BUREAU V. 3.

AUG 16 1956

RECEIVED

7976

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY

BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN

GARRISON

LENGTH OF STAY (in this place)

45 YRS.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

GARRISON Post Office

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

MARYLAND

COUNTY

BALTO

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

TOWN

GARRISON

STREET ADDRESS

GARRISON Post Office

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

ANNE TRIPLET HARRISON BRUNE

4. DATE OF DEATH

(Month)

(Day)

(Year)

AUG. 26 1956

5. SEX:

FEMALE

6. COLOR OR RACE:

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

WIDOWED

8. DATE OF BIRTH:

OCT. 10. 1869

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

86 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, (If retired, give occupation)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

CHARLES KUNN HARRISON

14. MOTHER'S MAIDEN NAME:

LOUISA TRIPLET HAXALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

YES

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

MRS. RICHARD HEIZMANN GARRISON P.O. BALTO. CO. MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0
Immediate cause

(a)

DUE TO

Myocardial infarction

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

Atherosclerotic Heart Disease

(c)

Interval Between Onset And Death

4 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 3, 1955, to Aug 26, 1956, that I last saw the deceased

alive on Aug 26, 1956, and that death occurred at 11:30 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION City, town, or county

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

8/18/56

H.W. Hedrick

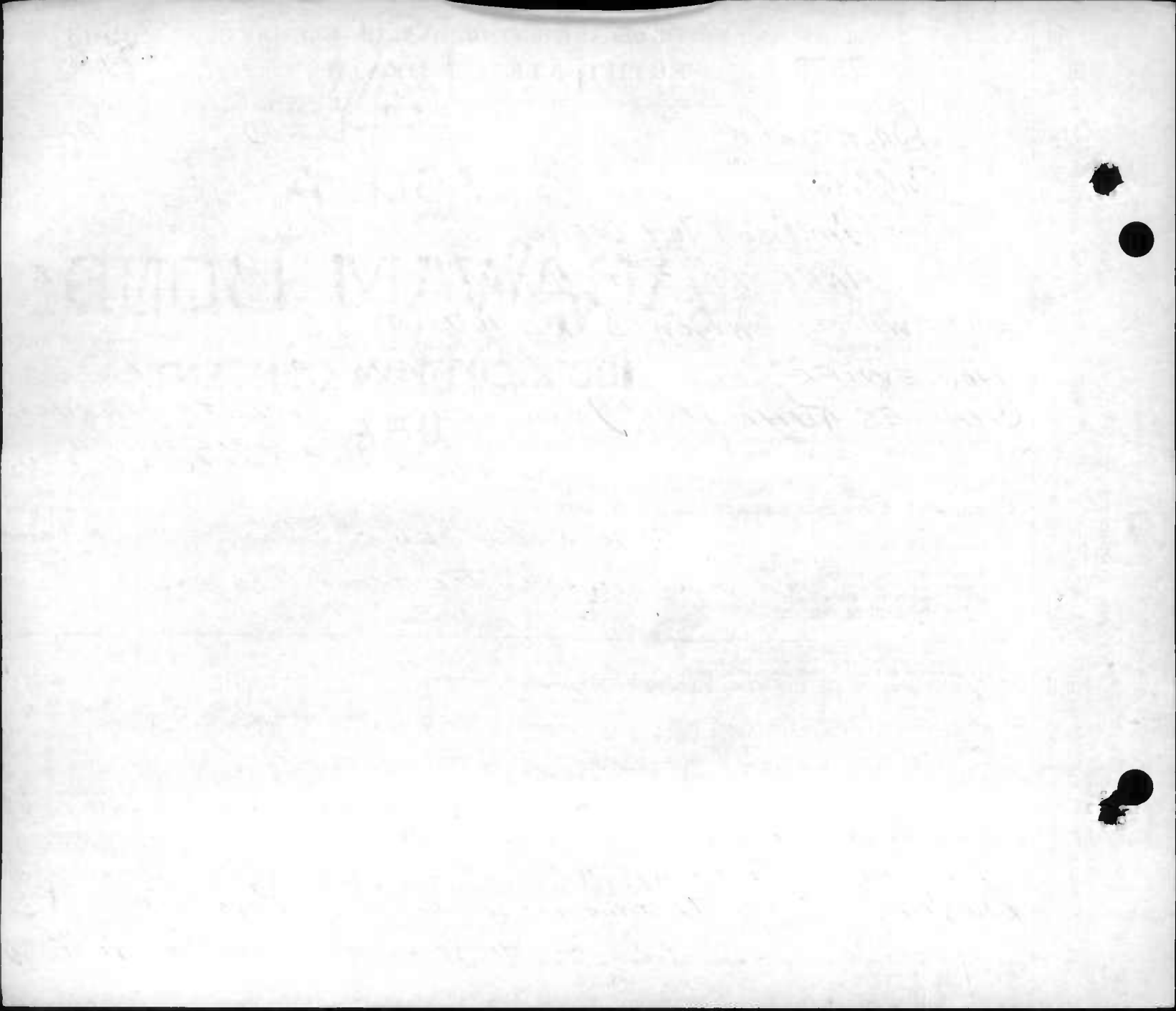
HENRY W. JENTINS & Sons Co.

4905 80

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07943
38

7977

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ruxton, Md.			c. LENGTH OF STAY IN 1b 10 Days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sorrenson Nursing Home				d. STREET ADDRESS 1413 Malvern		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary First V Middle Burchard Last				4. DATE OF DEATH August Month 16 Day 1956 Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 28, 1868	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper				10b. KIND OF BUSINESS OR INDUSTRY Club		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Patrick O. Conor				14. MOTHER'S MAIDEN NAME Mary O. McDermitt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. David Maulsby Address Baltimore, Md.				1413 Malvern Ave.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive failure DUE TO (b) arteriosclerotic heart disease DUE TO (c) Venous insufficiency of the legs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 2 months year year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 10 , 19 56 , to Aug 16 , 19 56 , that I last saw the deceased alive on Aug 10 , 19 56 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ernest C. Brown Jr. M.D.				ADDRESS (Street, city or town, state) 1101 N. Calvert St		DATE SIGNED Aug 17, 1956	
PHYSICIAN'S NAME (Type) Ernest Brown, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-27-56		22c. NAME OF CEMETERY OR CREMATORY Fernwood Cemetery		22d. LOCATION (City, town, or county) (State) Fernwood, Pa. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank A. Newell, Baltimore ADDRESS				24a. REC'D BY REGISTRAR Aug 21 1956		24b. REGISTRAR'S SIGNATURE Mabel Gray	

AUG 21 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07944

7978

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere		c. LENGTH OF STAY IN 1b 62 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 381, North Point Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SUSAN Middle L. BURKHARDT Last		4. DATE OF DEATH Month August Day 13 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1871
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennæ.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Mengle		14. MOTHER'S MAIDEN NAME Susan Bell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert E. Burkhardt		Address 1913 Queensway.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 20 years.		INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1956 to Aug 13, 1956 , that I last saw the deceased alive on Aug 10, 1956 , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE R.G. Windsor		M.D. 520 D St. S.P. 15	
PHYSICIAN'S NAME (Type) R.G. WINDSOR		DATE SIGNED 8/14/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Aug. 16, 1956	
22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Manheim, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home		ADDRESS 2112 Dundalk Ave.	
24a. RECEIVED BY REGISTRAR Aug 20 1956		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

CERTIFICATE OF DEATH

1957

PLACE TO BE FILLED BY THE REGISTRAR		PLACE TO BE FILLED BY THE DEATH INVESTIGATOR	
NAME OF DECEASED		NAME OF DEATH INVESTIGATOR	
AGE		SEX	
DATE OF BIRTH		DATE OF DEATH	
PLACE OF BIRTH		PLACE OF DEATH	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL HISTORY	
EDUCATION		PREVIOUS ILLNESS	
RELIGION		TREATMENT	
MARITAL STATUS		POST-MORTEM EXAMINATION	
SIGNED AND SWORN TO before me this _____ day of _____, 1957		SIGNED AND SWORN TO before me this _____ day of _____, 1957	
SUBSCRIBED AND SWORN TO before me this _____ day of _____, 1957		SUBSCRIBED AND SWORN TO before me this _____ day of _____, 1957	
NOTARY PUBLIC		NOTARY PUBLIC	
COMMISSION EXPIRES _____		COMMISSION EXPIRES _____	
OFFICE OF THE REGISTRAR		OFFICE OF THE DEATH INVESTIGATOR	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	

BUREAU V. 2

AUG 20 1956

RECEIVED

Ullrich (Lynch) Room 215 Wacker Ave.

7979

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 62 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JULIUS Middle M. Last CAPCINSKI				4. DATE OF DEATH Month August Day 31 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 16, 1918	
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months 38 Days 38 Hours 38 Min. 38		IF UNDER 24 HRS. Months 38 Days 38 Hours 38 Min. 38			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker				10b. KIND OF BUSINESS OR INDUSTRY Drug Company		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Waclaw Capcinski				14. MOTHER'S MAIDEN NAME Stephanie Wlodkowski			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II				16. SOCIAL SECURITY NO. 218-10-9475			
17. INFORMANT Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TESTICULAR TUMOR, TYPE UNKNOWN DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS - DURATION UNKNOWN							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) VA				(County)		(State)	
21. I certify that I attended the deceased from June 30, 1956 , to August 31, 1956 , and that death occurred at 10:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 8/31/56							
ACTUAL SIGNATURE Irving Freeman M.D. VAH, FORT HOWARD, MARYLAND							
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Acting Chief, Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Sept. 4, 1956		22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery	
22d. LOCATION (City, town, or county) Baltimore, Maryland				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE George A. Weber				ADDRESS 705 S. Ann Street, Balto.		24a. REC'D BY REGISTRAR SEP 4 1956	
24b. REGISTRAR'S SIGNATURE Dawson L. Laney							

George A. Weber Funeral Home

Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF REGISTRAR		10. SIGNATURE OF WITNESS	
JAMES EARL RAY		Male		35		White		April 4, 1968		Baltimore, Maryland		Suicide		Homicide		[Signature]		[Signature]	
11. PLACE OF BIRTH		12. DATE OF BIRTH		13. PLACE OF DEATH		14. DATE OF DEATH		15. PLACE OF DEATH		16. DATE OF DEATH		17. PLACE OF DEATH		18. DATE OF DEATH		19. PLACE OF DEATH		20. DATE OF DEATH	
Memphis, Tennessee		May 19, 1932		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968	
19. PLACE OF DEATH		20. DATE OF DEATH		21. PLACE OF DEATH		22. DATE OF DEATH		23. PLACE OF DEATH		24. DATE OF DEATH		25. PLACE OF DEATH		26. DATE OF DEATH		27. PLACE OF DEATH		28. DATE OF DEATH	
Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968	
29. PLACE OF DEATH		30. DATE OF DEATH		31. PLACE OF DEATH		32. DATE OF DEATH		33. PLACE OF DEATH		34. DATE OF DEATH		35. PLACE OF DEATH		36. DATE OF DEATH		37. PLACE OF DEATH		38. DATE OF DEATH	
Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968	
39. PLACE OF DEATH		40. DATE OF DEATH		41. PLACE OF DEATH		42. DATE OF DEATH		43. PLACE OF DEATH		44. DATE OF DEATH		45. PLACE OF DEATH		46. DATE OF DEATH		47. PLACE OF DEATH		48. DATE OF DEATH	
Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968	
49. PLACE OF DEATH		50. DATE OF DEATH		51. PLACE OF DEATH		52. DATE OF DEATH		53. PLACE OF DEATH		54. DATE OF DEATH		55. PLACE OF DEATH		56. DATE OF DEATH		57. PLACE OF DEATH		58. DATE OF DEATH	
Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968	
59. PLACE OF DEATH		60. DATE OF DEATH		61. PLACE OF DEATH		62. DATE OF DEATH		63. PLACE OF DEATH		64. DATE OF DEATH		65. PLACE OF DEATH		66. DATE OF DEATH		67. PLACE OF DEATH		68. DATE OF DEATH	
Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968	
69. PLACE OF DEATH		70. DATE OF DEATH		71. PLACE OF DEATH		72. DATE OF DEATH		73. PLACE OF DEATH		74. DATE OF DEATH		75. PLACE OF DEATH		76. DATE OF DEATH		77. PLACE OF DEATH		78. DATE OF DEATH	
Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968	
79. PLACE OF DEATH		80. DATE OF DEATH		81. PLACE OF DEATH		82. DATE OF DEATH		83. PLACE OF DEATH		84. DATE OF DEATH		85. PLACE OF DEATH		86. DATE OF DEATH		87. PLACE OF DEATH		88. DATE OF DEATH	
Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968	
89. PLACE OF DEATH		90. DATE OF DEATH		91. PLACE OF DEATH		92. DATE OF DEATH		93. PLACE OF DEATH		94. DATE OF DEATH		95. PLACE OF DEATH		96. DATE OF DEATH		97. PLACE OF DEATH		98. DATE OF DEATH	
Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968	
99. PLACE OF DEATH		100. DATE OF DEATH		101. PLACE OF DEATH		102. DATE OF DEATH		103. PLACE OF DEATH		104. DATE OF DEATH		105. PLACE OF DEATH		106. DATE OF DEATH		107. PLACE OF DEATH		108. DATE OF DEATH	
Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968		Baltimore, Maryland		April 4, 1968	

RECEIVED
SEP 5 1966
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7980 CERTIFICATE OF DEATH

07947

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>			c. LENGTH OF STAY IN 1b <u>Essex</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>416 Maryland Ave.</u>				d. STREET ADDRESS <u>416 Maryland Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Joseph - CARDARELLI</u>		First Middle Last		4. DATE OF DEATH <u>Aug. 31st, 1956</u>		Month Day Year <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 28th, 1891</u>		9. AGE (In years last birthday) <u>64</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U..S.A.</u>	
13. FATHER'S NAME <u>Thomas Cardarelli</u>				14. MOTHER'S MAIDEN NAME <u>Mary Musca</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-1059</u>		17. INFORMANT Address <u>Mrs. Letha Cardarelli (wife) Above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of bladder with metastases</u> 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>17 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arterio-sclerotic heart disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 27, 1956</u> to <u>Aug 31, 1956</u> , that I last saw the deceased alive on <u>Aug 31, 1956</u> , and that death occurred at <u>7:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph Miceli</u> M.D.				ADDRESS (Street, city or town, state) <u>423 Eastern Ave</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI M.D.</u>				DATE SIGNED <u>May 21, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 4th, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Eastern Blvd., Balto Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly</u>				ADDRESS <u>418 Eastern Blvd. Es</u>		24a. REC'D BY REGISTRAR <u>Edith Hurley</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>		DATE <u>SEP 5 1956</u>	

CERTIFICATE OF DEATH

1956

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

File No. 12

<p>1. Name of Deceased: <u>Joseph</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of Birth: <u>Aug. 11, 1922</u></p>		<p>4. Date of Death: <u>Aug. 11, 1956</u></p>	
<p>5. Place of Birth: <u>St. Louis, Mo.</u></p>		<p>6. Place of Death: <u>St. Louis, Mo.</u></p>	
<p>7. Usual Residence: <u>St. Louis, Mo.</u></p>		<p>8. Cause of Death: <u>Heart Disease</u></p>	
<p>9. Immediate Cause: <u>Myocardial Infarction</u></p>		<p>10. Underlying Cause: <u>Coronary Artery Disease</u></p>	
<p>11. Manner of Death: <u>Natural</u></p>		<p>12. Signature of Physician: <u>[Signature]</u></p>	
<p>13. Signature of Registrar: <u>[Signature]</u></p>		<p>14. Date of Registration: <u>Aug. 11, 1956</u></p>	

BUREAU V. S.

SEP 5 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07948

7949

CERTIFICATE OF DEATH

Reg. Dist. No.

47

1. PLACE OF DEATH a. COUNTY Baltimore, Halethorpe, 27 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe, Md. 27	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 5714 First Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Willard A. Clark				4. DATE OF DEATH Month Day Year Aug. 16 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 31st 1900	
9. AGE (In years last birthday) yrs. 55		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Linesman				10b. KIND OF BUSINESS OR INDUSTRY C.P. Telephone		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ashbury Clark				14. MOTHER'S MAIDEN NAME Ella Ray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. 212-10-0356		17. INFORMANT Address Elizabeth Clark 5714 First Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 mos.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 10, 1956, to Aug. 16, 1956, that I last saw the deceased alive on Aug 15, 1956, and that death occurred at 5:00 AM, from the causes and on the date stated above. ACTUAL SIGNATURE John D. Dumlér M.D. ADDRESS (Street, city or town, state) 1245 Graystone Rd DATE SIGNED 8/17/56 PHYSICIAN'S NAME (Type) Dr. John D. Dumlér							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 20-56		22c. NAME OF CEMETERY OR CREMATORY Friendship Cem.		22d. LOCATION (City, town, or county) (State) A.A. Co.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 5646 Carville Ave.				24a. REC'D BY REGISTRAR DATE AUG 20 1956		24b. REGISTRAR'S SIGNATURE Dr. Leo M. Kuffner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7981

CERTIFICATE OF DEATH

Reg. Dist. 118.

079433

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UPPER CO</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UPPER CO</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EMORY ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HAL</u> Middle <u>ROBERTSON</u> Last <u>CLAY</u>				4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 6, 1898</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>2</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B+O Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS R. CLAY</u>				14. MOTHER'S MAIDEN NAME <u>LILLIE ROBERTSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>705-05-7420</u>		17. INFORMANT <u>MRS HAL R. CLAY</u> Address <u>707 Glenwood Ave Balt.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSION</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>YEARS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify, that I attended the deceased from <u>Feb 15</u> , 19 <u>56</u> , to <u>August</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>August 2</u> , 19 <u>56</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clarence E. McWilliams</u> M.D.				ADDRESS (Street, city or town, state) <u>Reisterstown, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>CLARENCE E. McWILLIAMS</u>				DATE SIGNED <u>August 2, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 6, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Powell Baptist Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Norris City, Ill.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co., Inc.</u>				24a. REC'D BY REGISTRAR <u>Aug 5 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>	

4905 YORK RD.

CERTIFICATE OF DEATH

181

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
Robertson, Mary		F		40		1-1-1915		1-1-1956		Baltimore, Md.		Heart Disease		Natural		[Signature]		[Signature]	
11. Name of informant		12. Relationship		13. Address		14. City		15. State		16. Country		17. Date of completion		18. Registrar's name		19. Registrar's title		20. Registrar's address	
Mary Robertson		Wife		1234 Main St.		Baltimore		Md.		U.S.A.		1-1-1956		John Doe		Registrar		1234 Main St.	

BUREAU V. 4

AUG 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7982
CERTIFICATE OF DEATH

07950 38
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 911 Boyce Avenue				d. STREET ADDRESS 911 Boyce Avenue #4			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALLEN Middle K. Last CLIFTON				4. DATE OF DEATH Month August Day 4 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/6/1875		9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Steamship Co.		11. BIRTHPLACE (State or foreign country) Dorchester County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME ? Willis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-01-6184 Yes		17. INFORMANT Address Mrs. Roland C. Suter-911 Boyce Avenue #4			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiac vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 minutes 15 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 55 , to Aug , 19 56 , that I last saw the deceased alive on July 16, 1956 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE A. Allan Spier ADDRESS (Street, city or town, state) 4408 Loch Raven Blvd DATE SIGNED 8/9/56 PHYSICIAN'S NAME (Type) A. ALLAN SPIER BALTIMORE 18 MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/7/56		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tucker Sons - 1000 York Ave - Balt - 72 Md				24. REC'D BY REGISTRAR Aug. 7, 1956		24b. REGISTRAR'S SIGNATURE Nabel Gray	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. OCCUPATION [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MANNER OF DEATH [Faint text]</p>		<p>10. TIME OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>13. DATE OF DEATH [Faint text]</p>		<p>14. TIME OF DEATH [Faint text]</p>	
<p>15. PLACE OF DEATH [Faint text]</p>		<p>16. PLACE OF DEATH [Faint text]</p>	
<p>17. PLACE OF DEATH [Faint text]</p>		<p>18. PLACE OF DEATH [Faint text]</p>	
<p>19. PLACE OF DEATH [Faint text]</p>		<p>20. PLACE OF DEATH [Faint text]</p>	
<p>21. PLACE OF DEATH [Faint text]</p>		<p>22. PLACE OF DEATH [Faint text]</p>	
<p>23. PLACE OF DEATH [Faint text]</p>		<p>24. PLACE OF DEATH [Faint text]</p>	
<p>25. PLACE OF DEATH [Faint text]</p>		<p>26. PLACE OF DEATH [Faint text]</p>	
<p>27. PLACE OF DEATH [Faint text]</p>		<p>28. PLACE OF DEATH [Faint text]</p>	
<p>29. PLACE OF DEATH [Faint text]</p>		<p>30. PLACE OF DEATH [Faint text]</p>	
<p>31. PLACE OF DEATH [Faint text]</p>		<p>32. PLACE OF DEATH [Faint text]</p>	
<p>33. PLACE OF DEATH [Faint text]</p>		<p>34. PLACE OF DEATH [Faint text]</p>	
<p>35. PLACE OF DEATH [Faint text]</p>		<p>36. PLACE OF DEATH [Faint text]</p>	
<p>37. PLACE OF DEATH [Faint text]</p>		<p>38. PLACE OF DEATH [Faint text]</p>	
<p>39. PLACE OF DEATH [Faint text]</p>		<p>40. PLACE OF DEATH [Faint text]</p>	
<p>41. PLACE OF DEATH [Faint text]</p>		<p>42. PLACE OF DEATH [Faint text]</p>	
<p>43. PLACE OF DEATH [Faint text]</p>		<p>44. PLACE OF DEATH [Faint text]</p>	
<p>45. PLACE OF DEATH [Faint text]</p>		<p>46. PLACE OF DEATH [Faint text]</p>	
<p>47. PLACE OF DEATH [Faint text]</p>		<p>48. PLACE OF DEATH [Faint text]</p>	
<p>49. PLACE OF DEATH [Faint text]</p>		<p>50. PLACE OF DEATH [Faint text]</p>	
<p>51. PLACE OF DEATH [Faint text]</p>		<p>52. PLACE OF DEATH [Faint text]</p>	
<p>53. PLACE OF DEATH [Faint text]</p>		<p>54. PLACE OF DEATH [Faint text]</p>	
<p>55. PLACE OF DEATH [Faint text]</p>		<p>56. PLACE OF DEATH [Faint text]</p>	
<p>57. PLACE OF DEATH [Faint text]</p>		<p>58. PLACE OF DEATH [Faint text]</p>	
<p>59. PLACE OF DEATH [Faint text]</p>		<p>60. PLACE OF DEATH [Faint text]</p>	
<p>61. PLACE OF DEATH [Faint text]</p>		<p>62. PLACE OF DEATH [Faint text]</p>	
<p>63. PLACE OF DEATH [Faint text]</p>		<p>64. PLACE OF DEATH [Faint text]</p>	
<p>65. PLACE OF DEATH [Faint text]</p>		<p>66. PLACE OF DEATH [Faint text]</p>	
<p>67. PLACE OF DEATH [Faint text]</p>		<p>68. PLACE OF DEATH [Faint text]</p>	
<p>69. PLACE OF DEATH [Faint text]</p>		<p>70. PLACE OF DEATH [Faint text]</p>	
<p>71. PLACE OF DEATH [Faint text]</p>		<p>72. PLACE OF DEATH [Faint text]</p>	
<p>73. PLACE OF DEATH [Faint text]</p>		<p>74. PLACE OF DEATH [Faint text]</p>	
<p>75. PLACE OF DEATH [Faint text]</p>		<p>76. PLACE OF DEATH [Faint text]</p>	
<p>77. PLACE OF DEATH [Faint text]</p>		<p>78. PLACE OF DEATH [Faint text]</p>	
<p>79. PLACE OF DEATH [Faint text]</p>		<p>80. PLACE OF DEATH [Faint text]</p>	
<p>81. PLACE OF DEATH [Faint text]</p>		<p>82. PLACE OF DEATH [Faint text]</p>	
<p>83. PLACE OF DEATH [Faint text]</p>		<p>84. PLACE OF DEATH [Faint text]</p>	
<p>85. PLACE OF DEATH [Faint text]</p>		<p>86. PLACE OF DEATH [Faint text]</p>	
<p>87. PLACE OF DEATH [Faint text]</p>		<p>88. PLACE OF DEATH [Faint text]</p>	
<p>89. PLACE OF DEATH [Faint text]</p>		<p>90. PLACE OF DEATH [Faint text]</p>	
<p>91. PLACE OF DEATH [Faint text]</p>		<p>92. PLACE OF DEATH [Faint text]</p>	
<p>93. PLACE OF DEATH [Faint text]</p>		<p>94. PLACE OF DEATH [Faint text]</p>	
<p>95. PLACE OF DEATH [Faint text]</p>		<p>96. PLACE OF DEATH [Faint text]</p>	
<p>97. PLACE OF DEATH [Faint text]</p>		<p>98. PLACE OF DEATH [Faint text]</p>	
<p>99. PLACE OF DEATH [Faint text]</p>		<p>100. PLACE OF DEATH [Faint text]</p>	

BUREAU V. S.

AUG 8 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. The registrars remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7983 CERTIFICATE OF DEATH

0795145

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u> 54	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>104 Hall Con. Home</u>		d. STREET ADDRESS <u>2 Wilbur Road</u>	
3. NAME OF DECEASED (Type or print) <u>Robert LEO Clough</u> First Middle Last		4. DATE OF DEATH <u>8</u> Month <u>9</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 30, 1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TOOL MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AIRCRAFT</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>JAMES H. Clough</u>		14. MOTHER'S MAIDEN NAME <u>CELMA Bush</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>150-10-2377</u>	
17. INFORMANT <u>Wife -</u> Address <u>2 Wilbur Rd. Essex 21 Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Pancreas,</u> <u>157X</u> DUE TO <u>with metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 3, 1956</u> to <u>August 9, 1956</u> that I last saw the deceased alive on <u>August 9, 1956</u> and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E. Grosser</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 14, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Balto, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	24a. REC'D BY REGISTRAR <u>DATE 13 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>

CERTIFICATE OF DEATH

1803

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH	
[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]	
9. MARITAL STATUS		10. EDUCATION		11. RELIGION		12. RACE		13. COLOR		14. SEX		15. AGE		16. DATE OF DEATH	
[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]	
17. PLACE OF DEATH		18. CITY		19. COUNTY		20. STATE		21. ZIP CODE		22. MEDICAL HISTORY		23. PRESENT ILLNESS		24. TIME OF DEATH	
[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]	
25. SIGNATURE OF PHYSICIAN		26. SIGNATURE OF WITNESS		27. SIGNATURE OF DECEASED		28. SIGNATURE OF NEXT OF KIN		29. SIGNATURE OF CLERK		30. SIGNATURE OF REGISTRAR		31. SIGNATURE OF JUDGE		32. SIGNATURE OF SHERIFF	
[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]	

BUREAU V. 3

AUG 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07952

7984

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bendix Corporation				d. STREET ADDRESS 3142 Abell Avenue			
3. NAME OF DECEASED (Type or print) Louis Townsend Coffin				4. DATE OF DEATH Month August Day 17 Year 1956			
5. SEX MM	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 31, 1891	9. AGE (In years last birthday) yrs. 64	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William G. Coffin				14. MOTHER'S MAIDEN NAME Mamie M. Macklin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-03-0198		17. INFORMANT Mrs. Hester Coffin Address 3142 Abell Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerotic (cardio) vascular disease (c) ?						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1 , 19 56 , to Aug 17 , 19 56 , that I last saw the deceased alive on Aug 5 , 19 56 , and that death occurred at 5:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph S. Blum M.D.				DATE SIGNED 1115 h. Calver St			
PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD.				Baltimore - 2-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 21 Aug. 56		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home ADDRESS 4210 Belair Rd.				24. RECEIVED BY REGISTRAR AUG 22 1956		24b. REGISTRAR'S SIGNATURE Mabel Gray	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
HARRISON		JAN 10 1956	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
BIRTH DATE		BIRTH PLACE	
JAN 10 1891		BALTIMORE, MD	
MARRIAGE		OCCUPATION	
MARRIED		RETIRED	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
IMMEDIATE CAUSE		FUNDAMENTAL CAUSE	
CORONARY THROMBOSIS		HEART DISEASE	
DURATION OF ILLNESS		PLACE OF DEATH	
2 WEEKS		HOME	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
JAN 10 1956		BALTIMORE, MD	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 10 1956		JAN 10 1956	

BUREAU X. 1

AUG 22 1956

RECEIVED

7985

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 4124 PIMLICO ROAD			
3. NAME OF DECEASED (Type or print) First LOUIS Middle COHEN Last COHEN				4. DATE OF DEATH Month AUG. Day 28 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/29/1898		9. AGE (In years last birthday) yrs. 57	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WOLFE COHEN				14. MOTHER'S MAIDEN NAME HANNAH BASS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION WITH 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MYOCARDIAL INFARCTION DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 15 min.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 27 , 19 50 , to Aug 28 , 19 56 , that I last saw the deceased alive on Aug 28 , 19 56 , and that death occurred at 2:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Jerome E. Shapiro M.D.				ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED 8/28/56			
PHYSICIAN'S NAME (Type) Jerome E. Shapiro				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		8-29-56		Restland of Run		Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis				ADDRESS 2100 Eutaw Place		24a. REC'D BY REGISTRAR AUG 30 1956	
				24b. REGISTRAR'S SIGNATURE T. E. Harry			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

10

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

7. A. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 84

2025 RELEASE UNDER E.O. 14176

AUG 14 1956

RECEIVED

100

UREAU V. S.

AUG 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G201 8-11-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

07955

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riderwood		c. LENGTH OF STAY IN 1b 7666 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ruxway Nursing Home (Sorenson's Home)		d. STREET ADDRESS County Home	
3. NAME OF DECEASED (Type or print) First Middle Last GERTRUDE MARIA COOPER		4. DATE OF DEATH Month Day Year Aug. 6, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1884
9. AGE (In years) 72 yrs.		IF UNDER 1 YEAR Months Days 7 5	IF UNDER 24 HRS. Hours Min. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Herman G. Klotz	
14. MOTHER'S MAIDEN NAME Marie C. Friedericke		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Welfare Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Active congestion left lung. 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocarditis chronic with failure. DUE TO (c) Myocardial hypertrophy.			INTERVAL BETWEEN ONSET AND DEATH 3 weeks 2 months 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition advanced.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no injury	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) no injury	20f. (City or town) (County) (State) no injury
21. I certify that I attended the deceased from July 13, 1956 , to August 6, 1956 , that I last saw the deceased alive on July 31st, 1956 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James Graham Marston		ADDRESS (Street, city or town, state) 516 Cathedral Street Baltimore Md	
PHYSICIAN'S NAME (Type) James Graham Marston, M.D.		DATE SIGNED Aug. 8, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 8, 1956	22c. NAME OF CEMETERY OR CREMATORY May's Chapel Cemetery	22d. LOCATION (City, town, or county) (State) Timonium, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons		24a. REC'D BY REGISTRAR Aug. 8, 1956	
ADDRESS Towson, Maryland		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES J. JONES		MALE		35		JAN. 1, 1921	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION	
LABORER		HIGH SCHOOL		MARRIED		METHODIST	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
JULY 1, 1956		BALTIMORE		HEART DISEASE		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
J. J. Jones		J. J. Jones		J. J. Jones		J. J. Jones	

BUREAU V. 2

AUG 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7988

CERTIFICATE OF DEATH

07956

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Baltimore Md</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>				c. LENGTH OF STAY IN 1b <u>16 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood, Md.</u> <u>16 34 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>3806 Perry St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Maria</u> Middle <u>Cordone</u> Last <u>Cordone</u>				4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-19-82</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Europe</u> <input checked="" type="checkbox"/>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u> <u>--</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records: Spring Grove State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Diabetes - cerebral thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 1</u> , 19 <u>56</u> , to <u>August 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>August 15</u> , 19 <u>56</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Spring Grove State Hospital - 8-16-56</u> DATE SIGNED <u>John Vasconcellos</u>							
ACTUAL SIGNATURE <u>John Vasconcellos</u>		M.D. <u>Spring Grove State Hospital - 8-16-56</u>					
PHYSICIAN'S NAME (Type) <u>John Vasconcellos, M.D.</u>		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Belmont Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley Funeral Home, Inc. Baltimore</u>				ADDRESS <u>3200 R. D. Ave.</u>		24a. REC'D BY REGISTRAR <u>DATE 8/16/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>J.E. Harry</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35 years	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Room 306, LBJ Library, Washington, D.C.	
7. CITY OF DEATH Washington, D.C.		8. COUNTY OF DEATH District of Columbia		9. STATE OF DEATH District of Columbia	
10. MARITAL STATUS Single		11. OCCUPATION Attorney		12. CAUSE OF DEATH Suicide by gunshot	
13. MANNER OF DEATH Suicide		14. MEDICAL HISTORY No known chronic illness		15. PRESENT ILLNESS Depression	
16. DATE OF BIRTH January 10, 1933		17. PLACE OF BIRTH Jackson, Mississippi		18. EDUCATION Bachelor's degree	
19. RELIGION Methodist		20. SOCIAL SECURITY NUMBER [REDACTED]		21. SIGNATURE OF DECEASED [Signature]	
22. SIGNATURE OF PHYSICIAN [Signature]		23. SIGNATURE OF CORONER [Signature]		24. SIGNATURE OF WITNESS [Signature]	
25. SIGNATURE OF REGISTRAR [Signature]		26. SIGNATURE OF CLERK [Signature]		27. SIGNATURE OF JURY [Signature]	
28. SIGNATURE OF JURY [Signature]		29. SIGNATURE OF JURY [Signature]		30. SIGNATURE OF JURY [Signature]	

RECEIVED
AUG 17 1966
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07957											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 35-											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Parkton			c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Parkton						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Carmel Rd.					d. STREET ADDRESS Mt. Carmel Rd.			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES McHenry COX					4. DATE OF DEATH Month Day Year August 12 19 56						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, 1937		9. AGE (In years last birthday) 19 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Laurel, Pa.			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Roy M. Cox					14. MOTHER'S MAIDEN NAME Gertrude Hawkes						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		17. INFORMANT Address Roy M. Cox White Hall, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of the heart 976x DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in chest with 22 Rifle - Contact wound over heart								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Parkton-Rural Baltimore Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE R.S. Fisher					M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 8/13/56	
EXAMINER'S NAME (Type) R.S. Fisher					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 16, 1956		22c. NAME OF CEMETERY OR CREMATORY Stablersville, Cem.			22d. LOCATION (City, town, or county) (State) Parkton, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Jacob Hartenstein, New Freedom, Pa.					ADDRESS New Freedom, Pa.		24a. REC'D BY REGISTRAR 8/15/56		24b. REGISTRAR'S SIGNATURE Charles J. Eason		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
AUG 17 1956
BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07958

Reg. Dist. No. 37

7990

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 40 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WILMAR RD.		d. STREET ADDRESS WILMAR RD.	
3. NAME OF DECEASED (Type or print) MOLLIE ANN CRAUMER <small>First Middle Last</small>		4. DATE OF DEATH Month AUG Day 13 Year 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-10-1868
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? Fletcher Talbert		14. MOTHER'S MAIDEN NAME FLETCHER Darby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT Address Charles R. Craumer, Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DIS. DUE TO (c) 20 YRS			INTERVAL BETWEEN ONSET AND DEATH 5 MIN.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William A. Pillsbury		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED AUG. 13, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-16-56	22c. NAME OF CEMETERY OR CREMATORY Poplar Grove Methodist	22d. LOCATION (City, town, or county) (State) Cockeysville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks, Sparks, Md.		24a. REC'D BY REGISTRAR DATE 8/16/56	24b. REGISTRAR'S SIGNATURE Wm. J. Kirkpatrick

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

AUG 20 1956

RECEIVED

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. PLACE OF DEATH		9. DATE OF DEATH		10. TIME OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY		19. SIGNATURE OF JURY		20. SIGNATURE OF JURY	
21. SIGNATURE OF JURY		22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY		25. SIGNATURE OF JURY	
26. SIGNATURE OF JURY		27. SIGNATURE OF JURY		28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY		34. SIGNATURE OF JURY		35. SIGNATURE OF JURY	
36. SIGNATURE OF JURY		37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY		40. SIGNATURE OF JURY	
41. SIGNATURE OF JURY		42. SIGNATURE OF JURY		43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY		49. SIGNATURE OF JURY		50. SIGNATURE OF JURY	
51. SIGNATURE OF JURY		52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY		55. SIGNATURE OF JURY	
56. SIGNATURE OF JURY		57. SIGNATURE OF JURY		58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY		64. SIGNATURE OF JURY		65. SIGNATURE OF JURY	
66. SIGNATURE OF JURY		67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY		70. SIGNATURE OF JURY	
71. SIGNATURE OF JURY		72. SIGNATURE OF JURY		73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY		79. SIGNATURE OF JURY		80. SIGNATURE OF JURY	
81. SIGNATURE OF JURY		82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY		85. SIGNATURE OF JURY	
86. SIGNATURE OF JURY		87. SIGNATURE OF JURY		88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY		94. SIGNATURE OF JURY		95. SIGNATURE OF JURY	
96. SIGNATURE OF JURY		97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY		100. SIGNATURE OF JURY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7991

CERTIFICATE OF DEATH

07960

Reg. Dist. No.

35

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>	
c. LENGTH OF STAY IN 1b <u>73 yrs.</u>		d. STREET ADDRESS <u>Burke Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Burke Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William J. Cummings</u>		4. DATE OF DEATH <u>August 28, 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16, 1882</u>
9. AGE <u>73</u> years last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTH PLACE (State or foreign country) <u>White Hall, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert Cummings</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Almonex</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Asterio-sclerosis advanced</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u> <u>10-15 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>Aug 28, 1956</u> , to <u>Aug 28, 1956</u> , that I last saw the deceased alive on <u>Aug 28</u> , 19 <u>56</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>William O. Fulton</u> M.D.	DATE SIGNED <u>Aug 30 1956</u>
PHYSICIAN'S NAME (Type) <u>William O. Fulton</u> <u>Stewartstown, Pa.</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Aug 31, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Vernon Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>White Hall, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Kortenstern</u>		24a. REC'D BY REGISTRAR <u>8/31/56</u>	24b. REGISTRAR'S SIGNATURE <u>Charles J. Fulton</u>

CERTIFICATE OF DEATH

<p>NAME OF DECEASED <i>Robert Lawrence</i></p>		<p>DATE OF DEATH <i>Aug 2 1956</i></p>	
<p>AGE <i>30</i></p>		<p>SEX <i>Male</i></p>	
<p>DATE OF BIRTH <i>Aug 2 1926</i></p>		<p>PLACE OF BIRTH <i>St. Louis, Mo.</i></p>	
<p>RESIDENCE <i>1214 W. 1st St. Baltimore, Md.</i></p>		<p>OCCUPATION <i>Student</i></p>	
<p>CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>IMMEDIATE CAUSE <i>Coronary Thrombosis</i></p>	
<p>PERMANENT CAUSE <i>Coronary Atherosclerosis</i></p>		<p>INTERESTING FACTS <i>None</i></p>	
<p>SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>		<p>DATE <i>Aug 2 1956</i></p>	
<p>SIGNATURE OF REGISTRAR <i>[Signature]</i></p>		<p>DATE <i>Aug 2 1956</i></p>	

BUREAU Y. S.

SEP 5 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1807959 7950 CERTIFICATE OF DEATH Reg. Dist. No.									
1. PLACE OF DEATH:					2. USUAL RESIDENCE (HOME) OF DECEASED:				
COUNTY <u>Baltimore</u>		MARYLAND			STATE <u>MD</u>		COUNTY <u>Baltimore</u>		
CITY (If outside corporate limits, write OR and give nearest town) <u>51 Relay</u>		LENGTH OF STAY (in this place) <u>34 yrs</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Relay</u> <u>51</u>				
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5117 Rolling Rd</u>					STREET ADDRESS (If rural give location) <u>5117 Rolling Rd</u>				
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Howard Hearn Crobie</u>					4. DATE (Month) (Day) (Year) OF DEATH: <u>Aug 1 1936</u>				
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Sept 15 1874</u>		9. AGE last birthday <u>81</u> yrs.	
						IF UNDER 1 YEAR		IF UNDER 24 HRS.	
						Months		Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Chemical Engineer, Sharp & Horn</u>					10B. KIND OF BUSINESS OR INDUSTRY: <u>London, England</u>				
11. BIRTHPLACE (State or foreign country): <u>England</u>					12. CITIZEN OF WHAT COUNTRY? <u>England</u>				
13. FATHER'S NAME: <u>William M Crobie</u>					14. MOTHER'S MAIDEN NAME: <u>Emily Esth Hearn</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>157-12-3206</u>				
17. INFORMANT & ADDRESS: <u>Miss Diana Crobie 5117 Rolling Rd Relay Md</u>									
18. MEDICAL CERTIFICATION									
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH								INTERVAL BETWEEN ONSET AND DEATH	
177X IMMEDIATE CAUSE (A) <u>Carcinoma of Prostate</u>								<u>3 yrs</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Chronic Nephritis</u>								<u>6 mo</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>General arterio</u>								<u>10 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility</u>								<u>10 yrs</u>	
19A. DATE OF OPERATION:					19B. MAJOR FINDINGS OF OPERATION				
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)				
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?									
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY					21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				
21F. HOW DID INJURY OCCUR?									
22. I hereby certify that I attended the deceased from <u>Oct, 1936</u> to <u>Aug 1, 1936</u> that I last saw the deceased alive on <u>Aug 1, 1936</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.									
SIGNATURE <u>[Signature]</u>					ADDRESS <u>5117 Rolling Rd Relay Md</u>				
DATE SIGNED <u>8/1/36</u>									
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>					DATE THEREOF <u>Aug 3/36</u>				
NAME OF CEMETERY OR CREMATORY <u>Meadowridge Morsey, Md.</u>					LOCATION (City, town, or county) (State) <u>Relay Md</u>				
DATE REC'D BY LOCAL REGISTRAR <u>8-2-36</u>					REGISTRAR'S SIGNATURE <u>[Signature]</u>				
24. FUNERAL DIRECTOR <u>Harry H. Witte</u>					ADDRESS <u>4101 Edmondson</u>				

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

TO THE SECRETARY OF THE ARMY
FROM THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]

[Illegible text block]

[Illegible text block]

[Illegible text block]

[Illegible text block]

[Illegible text block]

[Illegible text block]

[Illegible text block]

[Illegible text block]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7992

CERTIFICATE OF DEATH

07961

Reg. Dist. No. 31

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Woodlawn</u>				TOWN <u>Woodlawn</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2114 Northland Road</u>				STREET ADDRESS (If rural give location) <u>2114 Northland Road</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Walter A. Curry</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>8/22/56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 30, 1875</u>	9. AGE last birthday <u>80</u> yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Alfred W. Curry</u>				14. MOTHER'S MAIDEN NAME <u>Mary Quigley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-09-9160</u>		17. INFORMANT & ADDRESS <u>E. Louise Curry, 2114 Northland Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebro-vascular Accident &</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Coronary artery disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Arterio-sclerosis.</u>							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/20</u> , 19 <u>56</u> , to <u>8/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/20</u> , 19 <u>56</u> , and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Milton Schlemmer</u>		ADDRESS (Street, city, town, state) <u>6710 Windsor Hill Rd.</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/27/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>AUG 24 1956</u>		REGISTRAR'S SIGNATURE <u>Dr. Wm. E. Martin</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William E. Martin</u> ADDRESS <u>4600 Liberty Hgts.</u>			

CERTIFICATE OF DEATH

1955, Dec. 11

A. HUSBAND (Name of Deceased)

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

1955, Dec. 11

MARYLAND

JOHN J. HARRIS

SMOOTH SURVIVAL

1. The purpose of this certificate is to provide a record of the death of a person who has died in Maryland. It is to be filled out by the attending physician or the medical examiner, or by the coroner if the death is sudden and unexpected. It is to be filed with the local health department and a copy sent to the State Department of Health. The information on this certificate is used for statistical purposes and to determine the cause of death.

BUREAU V. S.

AUG 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

07962

2411 N. Charles Street, Baltimore

7993

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balta.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u>	
TOWN <u>Edgemere</u>		TOWN <u>Edgemere</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7004 Riverdrive Road</u>		STREET ADDRESS (If rural, give location) <u>7004 Riverdrive Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Ignatius B. Cwalinga</u>		4. DATE OF DEATH <u>Aug 12 1956</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>Aug 14 1892</u>	
9. AGE last birthday <u>63</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Poland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Cwalinga</u>		14. MOTHER'S MAIDEN NAME <u>Alexandra Maliszewski</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>218-32-2708</u>	
17. INFORMANT <u>Mrs Helen Cwalinga</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause	(a) <u>Coronary Occlusion</u>	INTERVAL BETWEEN ONSET AND DEATH <u>.5 min.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Diabetes mellitus</u>	<u>7 yrs.</u>
260x	(c) <u>Coronary Occlusion</u>	<u>16 mo.</u>

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 28, 1956, to Aug. 12, 1956, that I last saw the deceasedalive on Aug. 12, 1956, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

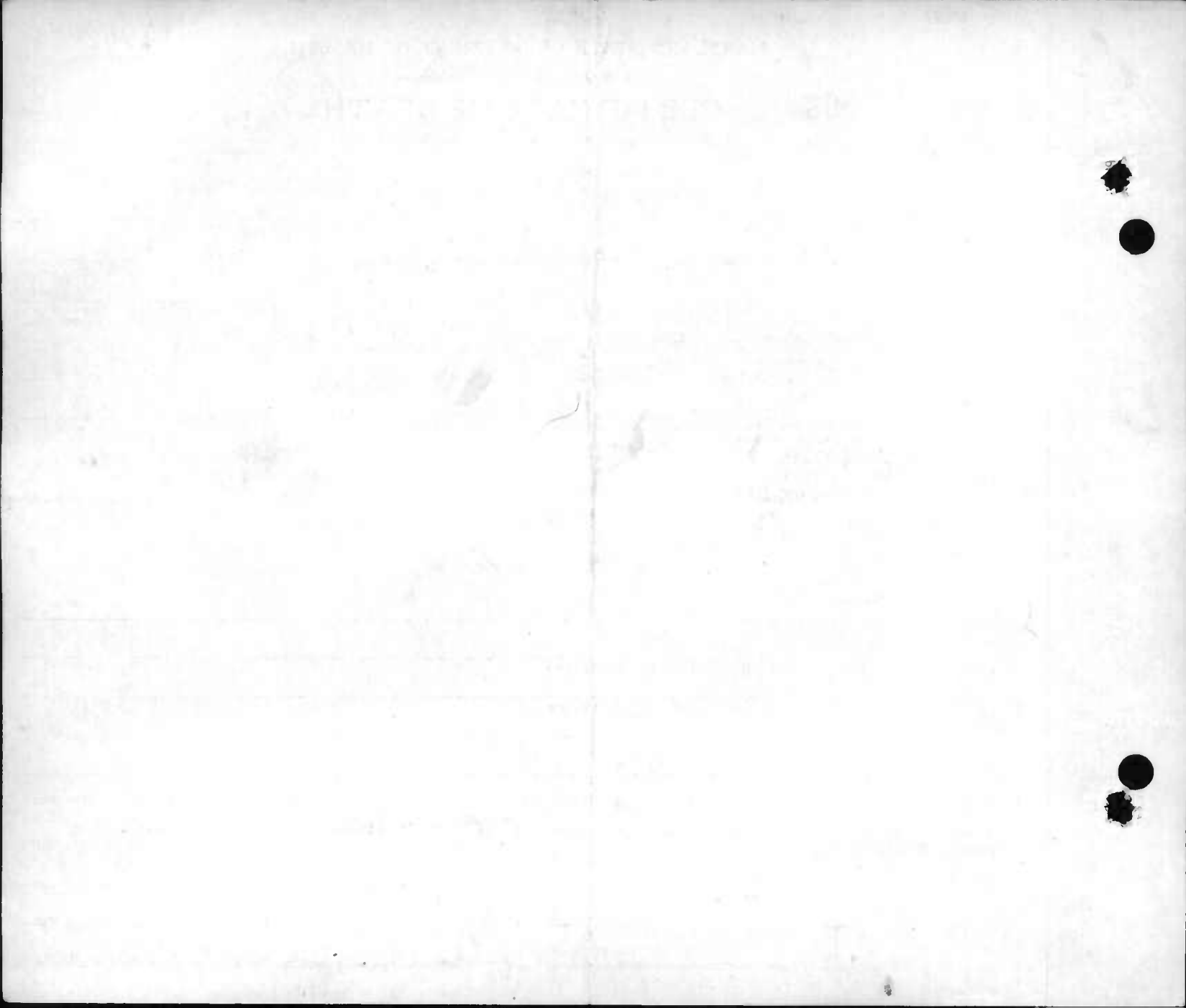
SIGNATURE David Owens, M.D. ADDRESS P.O. Box 140, 19, Md. DATE SIGNED 8/12/56

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF Aug 16/56 NAME OF CEMETERY OR CREMATORY Holy Rector's Cem LOCATION (City, town, or county) Balta. (State) County

DATE REC'D BY LOCAL REG. 8-17-56 REGISTRAR'S SIGNATURE John M. Weber 24. FUNERAL DIRECTOR ADDRESS 401 S. Charles

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7994 CERTIFICATE OF DEATH

0796333
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>		c. LENGTH OF STAY IN 1b <u>8 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Vernon Rd.</u>		d. STREET ADDRESS <u>Vernon Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Belinda Frances Dalton</u>		4. DATE OF DEATH <u>August 25</u> 19 <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20, 1883</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Meredith</u>		14. MOTHER'S MAIDEN NAME <u>Laura Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Chas Pearce</u>		Address <u>White Hall, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis - hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 4, 1956</u> , to <u>Aug. 25, 1956</u> , that I last saw the deceased alive on <u>Aug. 24, 1956</u> , and that death occurred at <u>10:25 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. France</u>		ADDRESS (Street, city or town, state) <u>Parkton, Md.</u> DATE SIGNED <u>8/27/56</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 28, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West Liberty Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>White Hall, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR <u>8/27/56</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Beeson</u>	

BUREAU V. 6

AUG 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7995 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07964
45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>			c. LENGTH OF STAY IN 1b 	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River 20.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glenn L. Martin Plant</u>				d. STREET ADDRESS <u>52 Transverse Court (Victory Village)</u>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-around;"> First <u>Claude</u> Middle Last <u>Dalton</u> </div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-around;"> Month <u>Aug.</u> Day <u>16th,</u> Year <u>1956</u> </div>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22, 1916</u>	9. AGE (In years last birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>24</u>	IF UNDER 24 HRS. Hours <u>24</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Glenn Martin Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME <u>Eugene Dalton</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Jennings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>224-05-5907</u>		17. INFORMANT Address <u>Jocie Dalton (Wife) Above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </div>						INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Jack C Collins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Jack C Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>8-17-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Aug. 17, 56</u>	22c. NAME OF CEMETERY OR CREMATORY 		22d. LOCATION (City, town, or county) (State) <u>Keeling, Virginia</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly</u>			ADDRESS <u>418 Eastern Blvd.,</u>		24a. REC'D BY REGISTRAR <u>AUG 21 1956</u>		
24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		COUNTY OF _____ CITY OF _____	
NAME OF DECEASED _____		SEX _____	
AGE _____		RACE _____	
DATE OF DEATH _____		PLACE OF DEATH _____	
TIME OF DEATH _____		OCCASION OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF EXAMINER _____		SIGNATURE OF WITNESS _____	
OFFICIAL SEAL _____		OFFICIAL SEAL _____	

BUREAU V. B.

AUG 21 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07965

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

44

7996

Items 8, 9 FilmG202 8-29-56 et

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethlehem Steel Co., Sparrows Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Co.		d. STREET ADDRESS 2002nd Lexington St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIE Middle MACK Last DAVIS		4. DATE OF DEATH Month August Day 16 Year 1956	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 29, 1948
9. AGE (In years last birthday) 7 yrs.		10. IF UNDER 1 YEAR Months 7 Days 16 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Surgeon operator		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co	
11. BIRTHPLACE (State or foreign country) Frederic, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Mack Davis		14. MOTHER'S MAIDEN NAME Rachel Jordan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 248-20-4594	
17. INFORMANT Walter Mack Davis		Address 401 Clairmont Ave Winston Salem, N.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing injury of chest and pelvis DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 902.3 DUE TO (a) stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently fell off the platform to pit	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 8/16 19 56 p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Plant		20f. (City or town) (County) (State) Baltimore Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R S Fisher		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/16/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Shipping		22b. DATE THEREOF Aug 16, 1956	
22c. NAME OF CEMETERY OR CREMATORY Winston Salem, N.C.		22d. LOCATION (City, town, or county) (State) Winston Salem, N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Mr. Kate R. Williams		ADDRESS 322 N. Schroeder St Balt. Md	
24a. REC'D BY REGISTRAR 21 1956		24b. REGISTRAR'S SIGNATURE Lawson L. Fisher	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 16
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Signature of Examiner		Date	
John Doe		Male		45		Jan 15 1910		New York City		123 Main St		Heart Disease		Natural		J. A. Smith		Jan 20 1956	
Occupation		Education		Marital Status		Previous Illnesses		Alcohol Consumption		Tobacco Use		Last Meal		Last Seen Alive		Signature of Informant		Date	
Teacher		High School		Married		Hypertension		Occasional		Daily		Dinner		19:00		M. J. Doe		Jan 20 1956	
Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker		Signature of Funeral Home		Signature of Cemetery		Signature of Mortuary		Signature of Embalmer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
 AUG 22 1956
 BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07966

7997

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 23 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUSSELL Middle W Last DEALE		4. DATE OF DEATH Month AUGUST Day 1 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-90
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		10b. KIND OF BUSINESS OR INDUSTRY UNEMPLOYED	
11. BIRTHPLACE (State or foreign country) DEALE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD DEALE		14. MOTHER'S MAIDEN NAME JULIA HARRISON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES <input checked="" type="checkbox"/> WW-1		16. SOCIAL SECURITY NO. 217-01-3856	
17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROSIS PERIPHERAL, WITH THROMBOSIS 4222 DUE TO DESCENDING AORTA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS, CEREBRAL DUE TO (c) MYOCARDITIS, CHRONIC		INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 10 YEARS 5 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GANGRENE LEFT LEG RELATED TO DIAGNOSIS #1		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 9 , 19 56 , to August 1 , 19 56 , and that death occurred at 11:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Md. DATE SIGNED 8/2/56			
ACTUAL SIGNATURE Walter J. Pijanowski		M.D. VAH, Fort Howard, Md.	
PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-6-56	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Inc.		ADDRESS 6009 Harford Road, Baltimore 14, Maryland	
24a. REC'D BY REGISTRAR Aug 7, 1956		24b. REGISTRAR'S SIGNATURE Dawson L. Taylor	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
BIRTH		DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SPECIAL INSTRUCTIONS	
FATHER		MOTHER		BROTHERS		SISTERS		CHILDREN		OTHER RELATIVES	
EDUCATION		OCCUPATION		MARRIAGE		MILITARY SERVICE		NAVY		ARMY	
RELIGION		POLITICAL PARTY		SOCIAL STATUS		ECONOMIC STATUS		LEGAL STATUS		OTHER STATUS	
DATE OF BIRTH		DATE OF DEATH		DATE OF BURIAL		DATE OF CREMATION		DATE OF INTERMENT		DATE OF REMOVAL	
PLACE OF BIRTH		PLACE OF DEATH		PLACE OF BURIAL		PLACE OF CREMATION		PLACE OF INTERMENT		PLACE OF REMOVAL	
CITY		COUNTY		STATE		COUNTRY		CONTINENT		WORLD	
ZIP CODE		CITY		COUNTY		STATE		COUNTRY		CONTINENT	
DATE OF BIRTH		DATE OF DEATH		DATE OF BURIAL		DATE OF CREMATION		DATE OF INTERMENT		DATE OF REMOVAL	
PLACE OF BIRTH		PLACE OF DEATH		PLACE OF BURIAL		PLACE OF CREMATION		PLACE OF INTERMENT		PLACE OF REMOVAL	
CITY		COUNTY		STATE		COUNTRY		CONTINENT		WORLD	
ZIP CODE		CITY		COUNTY		STATE		COUNTRY		CONTINENT	

BUREAU V. S.

AUG 8 1956

RECEIVED

RECEIVED
U.S. DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C.

7998

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>48 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>P.</u> Last <u>DERSCHINGER</u>		4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/10/94</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grain Elevator</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
13. FATHER'S NAME <u>Adam Derschinger</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Bergermeyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW-I</u>		16. SOCIAL SECURITY NO. <u>705 09 6465</u>	
17. INFORMANT <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Neuritis, right glossopharyngeal, greater auricular and lesser occipital nerves. Status post irradiation epidermoid carcinoma of tongue.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 6, 1956</u> , to <u>August 23, 1956</u> , from the time of admission to the hospital to the time of death , and that death occurred at <u>2:40 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph M. Miller</u>		ADDRESS (Street, city or town, state) <u>M.D. VAH, FORT HOWARD, MARYLAND</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH M. MILLER, M.D., Chief, Surgical Service, VAH, Fort Howard, Maryland</u>		DATE SIGNED <u>8/23/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 25, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Anne Arundel County, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gonce</u>		ADDRESS <u>4001 Ritchie Highway</u>	
24a. REC'D BY REGISTRAR <u>Aug 29 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Rawson L. Fisher</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1908

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MEDICAL HISTORY		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	
JAMES H. HARRIS		Male		35		White		Carpenter		New York		Jan 15 1873		Jan 20 1908		New York		Heart Disease		None		J. H. Harris		J. H. Harris		J. H. Harris	
15. PLACE OF INTERMENT		16. NAME OF INTERMENT		17. DATE OF INTERMENT		18. NAME OF MINISTER		19. NAME OF CHURCH		20. NAME OF FUNERAL HOME		21. NAME OF CEMETERY		22. NAME OF CITY		23. NAME OF STATE		24. NAME OF COUNTY		25. NAME OF DISTRICT		26. NAME OF TOWNSHIP		27. NAME OF WARD		28. NAME OF BLOCK	
New York		St. Paul's		Jan 20 1908		J. H. Harris		St. Paul's		New York		New York		New York		New York		New York		New York		New York		New York		New York	

RECEIVED
JUN 29 1956
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7999 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07968

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 34yr2mth10dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL			d. STREET ADDRESS Bay View Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Dix Last			4. DATE OF DEATH Month Aug. Day 23 Year 19 56		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1869		9. AGE (In years last birthday) 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Martin John Rigney			14. MOTHER'S MAIDEN NAME Ann Mary Taylor		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Pending Mitral Valvular disease DUE TO Rheumatic heart disease Conditions, if any, which gave rise to immediate cause (b) Old left ventricular myocardial infarct (c) arteriosclerosis DUE TO arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH years years
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Geo M Kieffer			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) George M. Kieffer, M. D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/25/56		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	
				22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balt. 17, Md.			24a. REC'D BY REGISTRAR DATE 8/28/56		24b. REGISTRAR'S SIGNATURE Victor C. Harry

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER OF THE GOSPEL		17. SIGNATURE OF CLERGYMAN		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF BURIAL PLACE		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF REINTERMENT		23. SIGNATURE OF REINTERMENT		24. SIGNATURE OF REINTERMENT	
25. SIGNATURE OF REINTERMENT		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT	
34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT	
40. SIGNATURE OF REINTERMENT		41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT	
43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
46. SIGNATURE OF REINTERMENT		47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT	
49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT	
52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT	
55. SIGNATURE OF REINTERMENT		56. SIGNATURE OF REINTERMENT		57. SIGNATURE OF REINTERMENT	
58. SIGNATURE OF REINTERMENT		59. SIGNATURE OF REINTERMENT		60. SIGNATURE OF REINTERMENT	
61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT	
64. SIGNATURE OF REINTERMENT		65. SIGNATURE OF REINTERMENT		66. SIGNATURE OF REINTERMENT	
67. SIGNATURE OF REINTERMENT		68. SIGNATURE OF REINTERMENT		69. SIGNATURE OF REINTERMENT	
70. SIGNATURE OF REINTERMENT		71. SIGNATURE OF REINTERMENT		72. SIGNATURE OF REINTERMENT	
73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT	
76. SIGNATURE OF REINTERMENT		77. SIGNATURE OF REINTERMENT		78. SIGNATURE OF REINTERMENT	
79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT		81. SIGNATURE OF REINTERMENT	
82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT	
85. SIGNATURE OF REINTERMENT		86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT	
88. SIGNATURE OF REINTERMENT		89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT	
94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT	
100. SIGNATURE OF REINTERMENT		101. SIGNATURE OF REINTERMENT		102. SIGNATURE OF REINTERMENT	

BUREAU V. 2

Aug 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07969 30

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines, 16 Fusting Ave				d. STREET ADDRESS 315 Westshire Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle B. Last Dixon				4. DATE OF DEATH Month Aug. Day 3 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1876		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Lonaconing, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James MacFarland				14. MOTHER'S MAIDEN NAME Annie Ritchie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Howard E. Jones, 315 Westshire Rd Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete Heart Block 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 day 7	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-7 , 19 50 , to 8-3 , 19 56 , that I last saw the deceased alive on 8-3 , 19 56 , and that death occurred at 8:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6209 Frederick Ave. DATE SIGNED ACTUAL SIGNATURE Wilmer K. Gallagher M.D. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher Baltimore-28, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 6/56		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke ADDRESS 4101 Edmondson Ave				24a. REC'D BY REGISTRAR DATE Aug 5 1956		24b. REGISTRAR'S SIGNATURE P. E. Harry	

CERTIFICATE OF DEATH

DECEASED NAME JAMES EARL RAY		SEX MALE	
DATE OF BIRTH JAN 5 1928		PLACE OF BIRTH MOBILE, ALABAMA	
OCCUPATION MEMBER OF CONGRESS		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH APR 4 1968		PLACE OF DEATH MEMPHIS, TENNESSEE	
TIME OF DEATH 10:00 AM		MANNER OF DEATH ACCIDENTAL	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

RECEIVED
 AUG 5 1956
 BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8001

CERTIFICATE OF DEATH

07970

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 94 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				d. STREET ADDRESS 1837 South Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ARCHIE Middle D. Last EASTON				4. DATE OF DEATH Month August Day 24 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/12/97	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Greens Keeper				10b. KIND OF BUSINESS OR INDUSTRY Golf Club		11. BIRTHPLACE (State or foreign country) Ellicott City, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Zed Easton				14. MOTHER'S MAIDEN NAME May Musgrove			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-I				16. SOCIAL SECURITY NO. 217-01-3989			
17. INFORMANT Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA WITH METASTASIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 22 , 19 56 , to August 24 , 19 56 , and that death occurred at 8:28 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Md. DATE SIGNED 8/25/56 ACTUAL SIGNATURE Arthur G. Edwards, M.D. PHYSICIAN'S NAME (Type) ARTHUR G. EDWARDS, M.D. VAH, Fort Howard, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-28-1956		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons 608 Frederick Ave. Baltimore, Maryland				24a. REC'D BY REGISTRAR Aug 29-56		24b. REGISTRAR'S SIGNATURE Dawson L. Farber	

BUREAU V. S.

1956 4 SEP

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07971

43

8002

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 423 A Bucks School House Rd.</u>		d. STREET ADDRESS <u>Box 423 A Bucks School House Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Carolyn</u> Middle <u>M.</u> Last <u>Eckenrode</u>		4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1919</u>
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Herman Bresnick</u>		14. MOTHER'S MAIDEN NAME <u>Mary Pfeiffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ernest G. Eckenrode</u>		Address <u>Box 423 A Bucks Sch. House Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(Hemorrhagic) Shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatosis</u> (c) <u>Adenocarcinoma, Corpus Uteri</u>		INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 8</u> , 19 <u>56</u> , to <u>August 28</u> 19 <u>56</u> that I last saw the deceased alive on <u>August 28</u> , 19 <u>56</u> , and that death occurred at <u>9:30 A.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8/29/56</u> DATE SIGNED			
ACTUAL SIGNATURE <u>John E. Gessner</u>		M.D. <u> </u>	
PHYSICIAN'S NAME (Type) <u>John E. Gessner, M.D.</u>		<u>201 Wise Avenue, Balto 22</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 31, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. L. L. Kiefer</u>	
DATE <u>30 1956</u>			

RECEIVED

AUG 30 1956

BUREAU V. 2

9:30V
August 2
July 8

Adenocarcinoma,

Carcinomatous

(Hemorrhagic)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8003

CERTIFICATE OF DEATH

Reg. Dist. No.

079724

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 30 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Also: (Howard First Middle Last) Edmondston F. EDMONSTON		4. DATE OF DEATH Month August Day 12 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 6, 1890
9. AGE (In years last birthday) yrs. 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boardman-Clerk	
10a. KIND OF BUSINESS OR INDUSTRY City Water Works		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Leonidas H. Edmonston	
14. MOTHER'S MAIDEN NAME Ida Poole		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> WW I	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE, LEFT ADRENAL 274X DUE TO UNKNOWN CAUSE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left transverse colectomy for carcinoma of colon 8/9/56		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 13, 1956 , to August 12, 1956 , and that death occurred at 3:58 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Irving Freeman M.D. VAH, FORT HOWARD, MARYLAND 8/13/56 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/15/56	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons - Balt 17		24a. REC'D BY REGISTRAR 14 1956	
24b. REGISTRAR'S SIGNATURE Lawson L. Taylor			

Wm. J. Tickner & Sons, Inc., North & Pennsylvania Aves., Baltimore, Md.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1910		Boston, Mass.		Boston, Mass.		Heart Disease		August 10, 1956		Boston, Mass.		5:00 PM		J. Doe, M.D.		A. Smith, Registrar	
Occupation		Marital Status		Education		Religion		Previous Illnesses		Last Medical Examination		Manner of Death		Burial or Cremation		Funeral Home		Burial Place		Crematorium		Remarks	
Teacher		Married		High School		Catholic		Hypertension		June 1, 1956		Natural		Buried		Doe & Sons		St. Mary's Church		Crematorium			
Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar		Remarks													
August 10, 1956		Boston, Mass.		5:00 PM		J. Doe, M.D.		A. Smith, Registrar															

RECEIVED
AUG 15 1956
BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07973

CERTIFICATE OF DEATH

Reg. Dist. No. 32

8904

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md. b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. LENGTH OF STAY IN 1b 3 mo. 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Hooper Elliott		4. DATE OF DEATH Month 8 Day 11 Year 1956	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/27/1894
9. AGE (In years lost birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 11 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto mechanic		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Elliott		14. MOTHER'S MAIDEN NAME Martha Lynch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-05-4415	
17. INFORMANT Hospital records		Address Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cot Pulmonale DUE TO 241X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Emphysema (c) Chronic Bronchial Asthma		INTERVAL BETWEEN ONSET AND DEATH 4 months 8 years 13 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X Minimal Pulmonary tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/1 , 19 56 , to 8/11 , 19 56 , that I last saw the deceased alive on 8/11 , 19 56 , and that death occurred at 2:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED William Newcomer M.D. William Newcomer, M.D. Mt. Wilson Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-15-56	
22c. NAME OF CEMETERY OR CREMATORY Morland Men Bur		22d. LOCATION (City, town, or county) (State) Taylor Ave.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Chensworth		24a. REC'D BY REGISTRAR Aug. 15, 1956	
24b. REGISTRAR'S SIGNATURE Snoddy Russell			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Aug 15 1956</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>	
40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>	
64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>	
70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>	
82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>	
88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

RECEIVED
AUG 15 1956
BUREAU V. E.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

PLACE OF DEATH COUNTY		MARSHALL	
A. DATE OF DEATH		JULY 10 1956	
B. TIME OF DEATH		10:00 AM	
C. PLACE OF DEATH		HOME	
D. NAME OF DECEASED		JOHN J. BROWN	
E. SEX		MALE	
F. AGE		65	
G. OCCUPATION		FARMER	
H. CAUSE OF DEATH		HEART DISEASE	
I. MANNER OF DEATH		NATURAL	
J. SIGNATURE OF PHYSICIAN		[Signature]	
K. SIGNATURE OF REGISTRAR		[Signature]	
L. SIGNATURE OF WITNESS		[Signature]	
M. SIGNATURE OF DECEASED		[Signature]	
N. SIGNATURE OF NEXT OF KIN		[Signature]	
O. SIGNATURE OF CLERGYMAN		[Signature]	
P. SIGNATURE OF BURIAL		[Signature]	
Q. SIGNATURE OF CREMATION		[Signature]	
R. SIGNATURE OF OTHER		[Signature]	
S. SIGNATURE OF OTHER		[Signature]	
T. SIGNATURE OF OTHER		[Signature]	
U. SIGNATURE OF OTHER		[Signature]	
V. SIGNATURE OF OTHER		[Signature]	
W. SIGNATURE OF OTHER		[Signature]	
X. SIGNATURE OF OTHER		[Signature]	
Y. SIGNATURE OF OTHER		[Signature]	
Z. SIGNATURE OF OTHER		[Signature]	

BUREAU V. 5

JUL 9 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8906

CERTIFICATE OF DEATH

Reg. Dist. No. 07975

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Md.	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) Colgate	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) Colgate	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 438 S. Oriole Ave.		STREET ADDRESS (If rural give location) 438 S. Oriole Ave.	
3. NAME OF DECEASED: (First) (Middle) (Last) JAMES K. EVERETT-EVERTS		4. DATE (Month) (Day) (Year) OF DEATH: Aug. 17 1956.	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: Nov. 29, 1886
9. AGE last birthday 69 yrs.		10. BIRTHPLACE (State or foreign country): Baltimore, Md.	
11. BIRTHPLACE (State or foreign country): Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Frank Everett		14. MOTHER'S MAIDEN NAME: Katherine ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) No (If Yes, give war or dates of service) ----		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: Sophia Everett		18. SAME. Same.	
15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Emaciation, Heart failure.		6 months	
ANTECEDENT CAUSE (S) Cancer of the pancreas.		about 2 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 16, 1956 , to August 17, 1956 , that I last saw the deceased alive on August 16, 1956 , and that death occurred at 9:55 A.M. M. from the causes and on the date stated above.			
SIGNATURE Eugene C. Baumann		DATE SIGNED 8/18/1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 8-20-56	
NAME OF CEMETERY OR CREMATORY SACRED HEART CEM		LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD. MD	
DATE REC'D BY LOCAL REGISTRAR Aug 20, 1956		REGISTRAR'S SIGNATURE G. C. Hedrich	
24. FUNERAL DIRECTOR Charles S. Geiler		ADDRESS 901 S. CONKLING ST. BALTO., MD.	

6394
EXST:RM AND

1

M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07976

8007

CERTIFICATE OF DEATH

Reg. Dist. No. 43 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Overlea Md.</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Overlea Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6801 Belair Rd.</u>				STREET ADDRESS (If rural give location) <u>6801 Belair Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>Samuel</u> (First) <u>F</u> (Middle) <u>Fatzinger</u> (Last)				4. DATE OF DEATH (Month) <u>8</u> (Day) <u>19</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 1 1890</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Martins</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Fatzinger</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie M. Danner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>176-01-5025</u>		17. INFORMANT & ADDRESS <u>Mr. Russell Fatzinger 4218 Cardwell Ave. 6</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
581.0 IMMEDIATE CAUSE (A) <u>Liver insufficiency. Coma</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cirrhosis of the liver</u>				<u>3 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/19</u> , 19 <u>56</u> , to <u>8/19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/19</u> , 19 <u>56</u> , and that death occurred at <u>1:30 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Eugene C. Baumann</u> M.D.				ADDRESS (Street, city, town, state) <u>1413 Eastern Ave., ESSEX</u> DATE SIGNED <u>8/19/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>Aug. 22, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR <u>15-2-1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. L. L. Reynolds</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd 6</u>	

4

(2.5.5)

— [(—)]

5

BUREAU V. S.

AUG 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8908

CERTIFICATE OF DEATH

Reg. Dist. No. 0797744

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 10 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				d. STREET ADDRESS 9025 Simms Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last FERGUSON				4. DATE OF DEATH Month August Day 6 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 7, 1894	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-proprietor				10b. KIND OF BUSINESS OR INDUSTRY Riding academy		11. BIRTHPLACE (State or foreign country) Harford Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Ferguson				14. MOTHER'S MAIDEN NAME Sarah Lutz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 27 , 19 56 , to August 6 , 19 56 , and that death occurred at 1:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Irving Freeman M.D. VAH, FORT HOWARD, MARYLAND 8/7/56 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-9-56		22c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery		22d. LOCATION (City, town, or county) (State) Harford County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home, 7401 Belair Road, Balto. Md.				24a. REC'D BY REGISTRAR Aug 8 1956			
24b. REGISTRAR'S SIGNATURE Dawson L. Farber							

CERTIFICATE OF DEATH

Date of Death August 8, 1956		Place of Death Home	
Name of Deceased John J. ...		Sex Male	
Date of Birth ...		Age ...	
Usual Residence ...		Cause of Death ...	
Medical History ...		Attending Physician ...	
Burial Place ...		Registrar ...	

BUREAU V. S.

AUG 8 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 11, 12 Film 201 8-20-56 et
8009
CERTIFICATE OF DEATH

07978

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 7700 York Rd.				d. STREET ADDRESS 7700 York Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HOWARD Middle O. Last FIROR				4. DATE OF DEATH Month Aug. Day 13, Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 30, 1874		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Excavating		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter O. Firor				14. MOTHER'S MAIDEN NAME Mary Ogle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. William H. Wiley, Jr.-6002 Lakeview Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr. Lymphatic Leukemia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension - St. Hemiplegia 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 4 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1952 to Aug 12 1956 that I last saw the deceased alive on Aug 4 1956 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city, or town, state) Baltimore Md. DATE SIGNED ACTUAL SIGNATURE Sheldon Eastland M.D. Med. Arts Bldg Baltimore Md. PHYSICIAN'S NAME (Type) J. Sheldon Eastland M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/56		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Vickener & Sons - Balto 17 Md.				24a. REC'D BY REGISTRAR DATE 8/14/56		24b. REGISTRAR'S SIGNATURE Mabel King	

CERTIFICATE OF DEATH

8-000

NAME OF DECEASED Baldwin		SEX Male		AGE 10		DATE OF BIRTH Nov. 10, 1945		PLACE OF BIRTH Baltimore, Md.		RACE White		RELIGION Roman Catholic		MARRIAGE Never married		EDUCATION Elementary		OCCUPATION Student		CAUSE OF DEATH Sudden		MANNER OF DEATH Natural		PLACE OF DEATH Home		DATE OF DEATH Aug. 15, 1956		TIME OF DEATH 10:00 AM		SIGNATURE OF PHYSICIAN J. Edgar Hoover		SIGNATURE OF REGISTRAR J. Edgar Hoover		SIGNATURE OF WITNESSES J. Edgar Hoover		SIGNATURE OF DECEASED J. Edgar Hoover																							
FATHER'S NAME J. Edgar Hoover		MOTHER'S NAME J. Edgar Hoover		FATHER'S OCCUPATION Student		MOTHER'S OCCUPATION Student		FATHER'S PLACE OF BIRTH Baltimore, Md.		MOTHER'S PLACE OF BIRTH Baltimore, Md.		FATHER'S RACE White		MOTHER'S RACE White		FATHER'S RELIGION Roman Catholic		MOTHER'S RELIGION Roman Catholic		FATHER'S MARRIAGE Never married		MOTHER'S MARRIAGE Never married		FATHER'S EDUCATION Elementary		MOTHER'S EDUCATION Elementary		FATHER'S OCCUPATION Student		MOTHER'S OCCUPATION Student		FATHER'S CAUSE OF DEATH Sudden		MOTHER'S CAUSE OF DEATH Sudden		FATHER'S MANNER OF DEATH Natural		MOTHER'S MANNER OF DEATH Natural		FATHER'S PLACE OF DEATH Home		MOTHER'S PLACE OF DEATH Home		FATHER'S DATE OF DEATH Aug. 15, 1956		MOTHER'S DATE OF DEATH Aug. 15, 1956		FATHER'S TIME OF DEATH 10:00 AM		MOTHER'S TIME OF DEATH 10:00 AM		FATHER'S SIGNATURE J. Edgar Hoover		MOTHER'S SIGNATURE J. Edgar Hoover		FATHER'S DECEASED J. Edgar Hoover		MOTHER'S DECEASED J. Edgar Hoover	

RECEIVED
AUG 15 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07979

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Wayne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>nr Chase</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Gunder Rd. West Twin River</u>				d. STREET ADDRESS <u>Wayne</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Fletcher</u> Last <u>Fletcher</u>				4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 27, 1889</u>		9. AGE (In years last birthday) <u>67</u> yrs.	10. IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>56</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto car</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph A. Fletcher</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Wilder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Larence C. Thomas</u>		Address <u>5301 Fernpark Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Heart</u>					
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M.B. Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M.B. DAVIS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Aug. 7, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>AUG 20 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Lachey</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

BUREAU V. S.

AUG 20 1956

RECEIVED

8011

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL (MONKTON)				c. LENGTH OF STAY IN 1b 30 yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BIG FALLS RD.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSHUA Middle BENJAMIN Last FOWBLE				4. DATE OF DEATH Month Aug Day 1 Year 1956			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/20/72	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN FOWBLE				14. MOTHER'S MAIDEN NAME ELLEN TONEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Address MRS. MAUDE ANDERSON SAME			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) 80 YRS						INTERVAL BETWEEN ONSET AND DEATH 1 MIN.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William A. Pillsbury M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-4-56	22c. NAME OF CEMETERY OR CREMATORY Providence Meth.		22d. LOCATION (City, town, or county) (State) Towson 4, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks, Sparks, Md.			24a. REC'D BY REGISTRAR DATE 8-6-56		24b. REGISTRAR'S SIGNATURE Mrs Howard S. Markline		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

AUG 8 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8012

CERTIFICATE OF DEATH

07981
30

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. LENGTH OF STAY IN 1b 4 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		d. STREET ADDRESS 1444 Cooksie St. Baltimore 30, Md.	
3. NAME OF DECEASED (Type or print) First Leonard Middle FREICHMAN Last Fleishman		4. DATE OF DEATH Month August Day 29 Year 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/19/1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY unknown	9. AGE (In years last birthday) 88 yrs.
11. BIRTHPLACE (State or foreign country) unknown BELGIUM		12. CITIZEN OF WHAT COUNTRY? unknown U.S.A.	
13. FATHER'S NAME unknown Leonard Freichman		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 2-12-14-8444	17. INFORMANT Mollie Kupfer 1211 Haubert St. Baltimore 30, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 12 , 19 56 , to August 29 , 19 56 , that I last saw the deceased alive on August 29 , 19 56 , and that death occurred at 8:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED 8-29-56			
ACTUAL SIGNATURE Stella Wachslar		M.D. Stella Wachslar	
PHYSICIAN'S NAME (Type) Stella Wachslar			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Sept 1, 1956	Trinity Cemetery	Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles F. Bell		24a. REC'D BY REGISTRAR AUG 31 1956	
ADDRESS 1501 E. Fort Ave.		24b. REGISTRAR'S SIGNATURE V. C. Harry	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>		<p>4. Place of birth: <u>John Doe, Baltimore, Md.</u></p>	
<p>5. Date of death: <u>Aug 1, 1956</u></p>		<p>6. Place of death: <u>John Doe, Baltimore, Md.</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>John Doe, M.D.</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	
<p>11. Signature of informant: <u>John Doe</u></p>		<p>12. Signature of witness: <u>John Doe</u></p>	
<p>13. Signature of funeral director: <u>John Doe</u></p>		<p>14. Signature of undertaker: <u>John Doe</u></p>	
<p>15. Signature of cemetery: <u>John Doe</u></p>		<p>16. Signature of burial: <u>John Doe</u></p>	
<p>17. Signature of interment: <u>John Doe</u></p>		<p>18. Signature of cremation: <u>John Doe</u></p>	
<p>19. Signature of other: <u>John Doe</u></p>		<p>20. Signature of other: <u>John Doe</u></p>	
<p>21. Signature of other: <u>John Doe</u></p>		<p>22. Signature of other: <u>John Doe</u></p>	
<p>23. Signature of other: <u>John Doe</u></p>		<p>24. Signature of other: <u>John Doe</u></p>	
<p>25. Signature of other: <u>John Doe</u></p>		<p>26. Signature of other: <u>John Doe</u></p>	
<p>27. Signature of other: <u>John Doe</u></p>		<p>28. Signature of other: <u>John Doe</u></p>	
<p>29. Signature of other: <u>John Doe</u></p>		<p>30. Signature of other: <u>John Doe</u></p>	
<p>31. Signature of other: <u>John Doe</u></p>		<p>32. Signature of other: <u>John Doe</u></p>	
<p>33. Signature of other: <u>John Doe</u></p>		<p>34. Signature of other: <u>John Doe</u></p>	
<p>35. Signature of other: <u>John Doe</u></p>		<p>36. Signature of other: <u>John Doe</u></p>	
<p>37. Signature of other: <u>John Doe</u></p>		<p>38. Signature of other: <u>John Doe</u></p>	
<p>39. Signature of other: <u>John Doe</u></p>		<p>40. Signature of other: <u>John Doe</u></p>	
<p>41. Signature of other: <u>John Doe</u></p>		<p>42. Signature of other: <u>John Doe</u></p>	
<p>43. Signature of other: <u>John Doe</u></p>		<p>44. Signature of other: <u>John Doe</u></p>	
<p>45. Signature of other: <u>John Doe</u></p>		<p>46. Signature of other: <u>John Doe</u></p>	
<p>47. Signature of other: <u>John Doe</u></p>		<p>48. Signature of other: <u>John Doe</u></p>	
<p>49. Signature of other: <u>John Doe</u></p>		<p>50. Signature of other: <u>John Doe</u></p>	
<p>51. Signature of other: <u>John Doe</u></p>		<p>52. Signature of other: <u>John Doe</u></p>	
<p>53. Signature of other: <u>John Doe</u></p>		<p>54. Signature of other: <u>John Doe</u></p>	
<p>55. Signature of other: <u>John Doe</u></p>		<p>56. Signature of other: <u>John Doe</u></p>	
<p>57. Signature of other: <u>John Doe</u></p>		<p>58. Signature of other: <u>John Doe</u></p>	
<p>59. Signature of other: <u>John Doe</u></p>		<p>60. Signature of other: <u>John Doe</u></p>	
<p>61. Signature of other: <u>John Doe</u></p>		<p>62. Signature of other: <u>John Doe</u></p>	
<p>63. Signature of other: <u>John Doe</u></p>		<p>64. Signature of other: <u>John Doe</u></p>	
<p>65. Signature of other: <u>John Doe</u></p>		<p>66. Signature of other: <u>John Doe</u></p>	
<p>67. Signature of other: <u>John Doe</u></p>		<p>68. Signature of other: <u>John Doe</u></p>	
<p>69. Signature of other: <u>John Doe</u></p>		<p>70. Signature of other: <u>John Doe</u></p>	
<p>71. Signature of other: <u>John Doe</u></p>		<p>72. Signature of other: <u>John Doe</u></p>	
<p>73. Signature of other: <u>John Doe</u></p>		<p>74. Signature of other: <u>John Doe</u></p>	
<p>75. Signature of other: <u>John Doe</u></p>		<p>76. Signature of other: <u>John Doe</u></p>	
<p>77. Signature of other: <u>John Doe</u></p>		<p>78. Signature of other: <u>John Doe</u></p>	
<p>79. Signature of other: <u>John Doe</u></p>		<p>80. Signature of other: <u>John Doe</u></p>	
<p>81. Signature of other: <u>John Doe</u></p>		<p>82. Signature of other: <u>John Doe</u></p>	
<p>83. Signature of other: <u>John Doe</u></p>		<p>84. Signature of other: <u>John Doe</u></p>	
<p>85. Signature of other: <u>John Doe</u></p>		<p>86. Signature of other: <u>John Doe</u></p>	
<p>87. Signature of other: <u>John Doe</u></p>		<p>88. Signature of other: <u>John Doe</u></p>	
<p>89. Signature of other: <u>John Doe</u></p>		<p>90. Signature of other: <u>John Doe</u></p>	
<p>91. Signature of other: <u>John Doe</u></p>		<p>92. Signature of other: <u>John Doe</u></p>	
<p>93. Signature of other: <u>John Doe</u></p>		<p>94. Signature of other: <u>John Doe</u></p>	
<p>95. Signature of other: <u>John Doe</u></p>		<p>96. Signature of other: <u>John Doe</u></p>	
<p>97. Signature of other: <u>John Doe</u></p>		<p>98. Signature of other: <u>John Doe</u></p>	
<p>99. Signature of other: <u>John Doe</u></p>		<p>100. Signature of other: <u>John Doe</u></p>	

BUREAU V. 8

AUG 31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8013

CERTIFICATE OF DEATH

Reg. Dist. No. 0798230

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. State . b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paradise Nursing Home, Paradise & Altamont Aves.		d. STREET ADDRESS 4704 Edmondson Ave.	
3. NAME OF DECEASED (Type or print) First Helen Middle Gabriel Last		4. DATE OF DEATH Aug. 29/56 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1874 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Paul Gabriel		14. MOTHER'S MAIDEN NAME Elise---	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Emmett MacCubbin, 762 Charing Cross Rd	
17. INFORMANT Emmett MacCubbin, 762 Charing Cross Rd		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CVD DUE TO (c) Unkown		INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-11 , 1952, to 8-29 , 1956, that I last saw the deceased alive on 8-21 , 1956, and that death occurred at 1:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 908 Frederick Rd Catonsville DATE SIGNED 8-29 ACTUAL SIGNATURE Stephen G. Hughes M.D. 8-29 PHYSICIAN'S NAME (Type) Harry H. Wiltsie			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 31/56	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Balto. 29, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Wiltsie		24a. REC'D BY REGISTRAR DATE 5 1956	
24b. REGISTRAR'S SIGNATURE H. E. Harvey			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1956</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. DATE OF BIRTH <i>Jan 15 1911</i>		11. TIME OF BIRTH <i>10:00 AM</i>		12. PLACE OF BIRTH <i>Baltimore, Md.</i>	
13. NAME OF PHYSICIAN <i>Dr. John Doe</i>		14. NAME OF NURSE <i>Miss Jane Doe</i>		15. NAME OF ATTENDING PHYSICIAN <i>Dr. John Doe</i>	
16. NAME OF HOSPITAL <i>St. Mary's Hospital</i>		17. NAME OF NURSING HOME <i>St. Mary's Nursing Home</i>		18. NAME OF OTHER PLACE <i>St. Mary's Hospital</i>	
19. NAME OF DECEASED'S WIFE <i>John Doe</i>		20. NAME OF DECEASED'S CHILDREN <i>John Doe</i>		21. NAME OF DECEASED'S SISTER <i>John Doe</i>	
22. NAME OF DECEASED'S BROTHER <i>John Doe</i>		23. NAME OF DECEASED'S NEPHEW <i>John Doe</i>		24. NAME OF DECEASED'S Nephew <i>John Doe</i>	
25. NAME OF DECEASED'S Niece <i>John Doe</i>		26. NAME OF DECEASED'S Niece <i>John Doe</i>		27. NAME OF DECEASED'S Niece <i>John Doe</i>	
28. NAME OF DECEASED'S Niece <i>John Doe</i>		29. NAME OF DECEASED'S Niece <i>John Doe</i>		30. NAME OF DECEASED'S Niece <i>John Doe</i>	
31. NAME OF DECEASED'S Niece <i>John Doe</i>		32. NAME OF DECEASED'S Niece <i>John Doe</i>		33. NAME OF DECEASED'S Niece <i>John Doe</i>	
34. NAME OF DECEASED'S Niece <i>John Doe</i>		35. NAME OF DECEASED'S Niece <i>John Doe</i>		36. NAME OF DECEASED'S Niece <i>John Doe</i>	
37. NAME OF DECEASED'S Niece <i>John Doe</i>		38. NAME OF DECEASED'S Niece <i>John Doe</i>		39. NAME OF DECEASED'S Niece <i>John Doe</i>	
40. NAME OF DECEASED'S Niece <i>John Doe</i>		41. NAME OF DECEASED'S Niece <i>John Doe</i>		42. NAME OF DECEASED'S Niece <i>John Doe</i>	
43. NAME OF DECEASED'S Niece <i>John Doe</i>		44. NAME OF DECEASED'S Niece <i>John Doe</i>		45. NAME OF DECEASED'S Niece <i>John Doe</i>	
46. NAME OF DECEASED'S Niece <i>John Doe</i>		47. NAME OF DECEASED'S Niece <i>John Doe</i>		48. NAME OF DECEASED'S Niece <i>John Doe</i>	
49. NAME OF DECEASED'S Niece <i>John Doe</i>		50. NAME OF DECEASED'S Niece <i>John Doe</i>		51. NAME OF DECEASED'S Niece <i>John Doe</i>	
52. NAME OF DECEASED'S Niece <i>John Doe</i>		53. NAME OF DECEASED'S Niece <i>John Doe</i>		54. NAME OF DECEASED'S Niece <i>John Doe</i>	
55. NAME OF DECEASED'S Niece <i>John Doe</i>		56. NAME OF DECEASED'S Niece <i>John Doe</i>		57. NAME OF DECEASED'S Niece <i>John Doe</i>	
58. NAME OF DECEASED'S Niece <i>John Doe</i>		59. NAME OF DECEASED'S Niece <i>John Doe</i>		60. NAME OF DECEASED'S Niece <i>John Doe</i>	
61. NAME OF DECEASED'S Niece <i>John Doe</i>		62. NAME OF DECEASED'S Niece <i>John Doe</i>		63. NAME OF DECEASED'S Niece <i>John Doe</i>	
64. NAME OF DECEASED'S Niece <i>John Doe</i>		65. NAME OF DECEASED'S Niece <i>John Doe</i>		66. NAME OF DECEASED'S Niece <i>John Doe</i>	
67. NAME OF DECEASED'S Niece <i>John Doe</i>		68. NAME OF DECEASED'S Niece <i>John Doe</i>		69. NAME OF DECEASED'S Niece <i>John Doe</i>	
70. NAME OF DECEASED'S Niece <i>John Doe</i>		71. NAME OF DECEASED'S Niece <i>John Doe</i>		72. NAME OF DECEASED'S Niece <i>John Doe</i>	
73. NAME OF DECEASED'S Niece <i>John Doe</i>		74. NAME OF DECEASED'S Niece <i>John Doe</i>		75. NAME OF DECEASED'S Niece <i>John Doe</i>	
76. NAME OF DECEASED'S Niece <i>John Doe</i>		77. NAME OF DECEASED'S Niece <i>John Doe</i>		78. NAME OF DECEASED'S Niece <i>John Doe</i>	
79. NAME OF DECEASED'S Niece <i>John Doe</i>		80. NAME OF DECEASED'S Niece <i>John Doe</i>		81. NAME OF DECEASED'S Niece <i>John Doe</i>	
82. NAME OF DECEASED'S Niece <i>John Doe</i>		83. NAME OF DECEASED'S Niece <i>John Doe</i>		84. NAME OF DECEASED'S Niece <i>John Doe</i>	
85. NAME OF DECEASED'S Niece <i>John Doe</i>		86. NAME OF DECEASED'S Niece <i>John Doe</i>		87. NAME OF DECEASED'S Niece <i>John Doe</i>	
88. NAME OF DECEASED'S Niece <i>John Doe</i>		89. NAME OF DECEASED'S Niece <i>John Doe</i>		90. NAME OF DECEASED'S Niece <i>John Doe</i>	
91. NAME OF DECEASED'S Niece <i>John Doe</i>		92. NAME OF DECEASED'S Niece <i>John Doe</i>		93. NAME OF DECEASED'S Niece <i>John Doe</i>	
94. NAME OF DECEASED'S Niece <i>John Doe</i>		95. NAME OF DECEASED'S Niece <i>John Doe</i>		96. NAME OF DECEASED'S Niece <i>John Doe</i>	
97. NAME OF DECEASED'S Niece <i>John Doe</i>		98. NAME OF DECEASED'S Niece <i>John Doe</i>		99. NAME OF DECEASED'S Niece <i>John Doe</i>	
100. NAME OF DECEASED'S Niece <i>John Doe</i>		101. NAME OF DECEASED'S Niece <i>John Doe</i>		102. NAME OF DECEASED'S Niece <i>John Doe</i>	

RECEIVED
SEP 5 1956
BUREAU Y. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8014 CERTIFICATE OF DEATH

07983
44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN b. 7 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 179 King George Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PETER Middle J. Last GALLAGHER		4. DATE OF DEATH Month August Day 6 Year 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 8, 1888
9. AGE (In years last birthday) yrs. 67		IF UNDER 1 YEAR Months 6 Days 19 Hours 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY U. S. Naval Academy	
11. BIRTHPLACE (State or foreign country) Sumter, S. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Peter J. Gallagher		14. MOTHER'S MAIDEN NAME Bridget Gallagher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Clin. Rec., Vet. Administration Hospital, Ft. Howard		Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HODGKIN'S DISEASE 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHIAL PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 8 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 30 , 19 56 , to August 6 , 19 56 , and that death occurred at 2:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 8/6/56 ACTUAL SIGNATURE Irving Freeman M.D. PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 9, 56	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Benjamin Hopping Funeral Home, West Street, Annapolis, Maryland		24a. REC'D BY REGISTRAR Aug 8 1956	
24b. REGISTRAR'S SIGNATURE Dawson L. Harvey			

CERTIFICATE OF DEATH

See 201.11

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. CAUSE OF DEATH [Illegible]		9. MANNER OF DEATH [Illegible]	
10. PLACE OF DEATH [Illegible]		11. TIME OF DEATH [Illegible]		12. SIGNATURE OF PHYSICIAN [Illegible]	
13. SIGNATURE OF REGISTRAR [Illegible]		14. SIGNATURE OF WITNESS [Illegible]		15. SIGNATURE OF DECEASED [Illegible]	
16. SIGNATURE OF DECEASED [Illegible]		17. SIGNATURE OF DECEASED [Illegible]		18. SIGNATURE OF DECEASED [Illegible]	
19. SIGNATURE OF DECEASED [Illegible]		20. SIGNATURE OF DECEASED [Illegible]		21. SIGNATURE OF DECEASED [Illegible]	
22. SIGNATURE OF DECEASED [Illegible]		23. SIGNATURE OF DECEASED [Illegible]		24. SIGNATURE OF DECEASED [Illegible]	
25. SIGNATURE OF DECEASED [Illegible]		26. SIGNATURE OF DECEASED [Illegible]		27. SIGNATURE OF DECEASED [Illegible]	
28. SIGNATURE OF DECEASED [Illegible]		29. SIGNATURE OF DECEASED [Illegible]		30. SIGNATURE OF DECEASED [Illegible]	
31. SIGNATURE OF DECEASED [Illegible]		32. SIGNATURE OF DECEASED [Illegible]		33. SIGNATURE OF DECEASED [Illegible]	
34. SIGNATURE OF DECEASED [Illegible]		35. SIGNATURE OF DECEASED [Illegible]		36. SIGNATURE OF DECEASED [Illegible]	
37. SIGNATURE OF DECEASED [Illegible]		38. SIGNATURE OF DECEASED [Illegible]		39. SIGNATURE OF DECEASED [Illegible]	
40. SIGNATURE OF DECEASED [Illegible]		41. SIGNATURE OF DECEASED [Illegible]		42. SIGNATURE OF DECEASED [Illegible]	
43. SIGNATURE OF DECEASED [Illegible]		44. SIGNATURE OF DECEASED [Illegible]		45. SIGNATURE OF DECEASED [Illegible]	
46. SIGNATURE OF DECEASED [Illegible]		47. SIGNATURE OF DECEASED [Illegible]		48. SIGNATURE OF DECEASED [Illegible]	
49. SIGNATURE OF DECEASED [Illegible]		50. SIGNATURE OF DECEASED [Illegible]		51. SIGNATURE OF DECEASED [Illegible]	
52. SIGNATURE OF DECEASED [Illegible]		53. SIGNATURE OF DECEASED [Illegible]		54. SIGNATURE OF DECEASED [Illegible]	
55. SIGNATURE OF DECEASED [Illegible]		56. SIGNATURE OF DECEASED [Illegible]		57. SIGNATURE OF DECEASED [Illegible]	
58. SIGNATURE OF DECEASED [Illegible]		59. SIGNATURE OF DECEASED [Illegible]		60. SIGNATURE OF DECEASED [Illegible]	
61. SIGNATURE OF DECEASED [Illegible]		62. SIGNATURE OF DECEASED [Illegible]		63. SIGNATURE OF DECEASED [Illegible]	
64. SIGNATURE OF DECEASED [Illegible]		65. SIGNATURE OF DECEASED [Illegible]		66. SIGNATURE OF DECEASED [Illegible]	
67. SIGNATURE OF DECEASED [Illegible]		68. SIGNATURE OF DECEASED [Illegible]		69. SIGNATURE OF DECEASED [Illegible]	
70. SIGNATURE OF DECEASED [Illegible]		71. SIGNATURE OF DECEASED [Illegible]		72. SIGNATURE OF DECEASED [Illegible]	
73. SIGNATURE OF DECEASED [Illegible]		74. SIGNATURE OF DECEASED [Illegible]		75. SIGNATURE OF DECEASED [Illegible]	
76. SIGNATURE OF DECEASED [Illegible]		77. SIGNATURE OF DECEASED [Illegible]		78. SIGNATURE OF DECEASED [Illegible]	
79. SIGNATURE OF DECEASED [Illegible]		80. SIGNATURE OF DECEASED [Illegible]		81. SIGNATURE OF DECEASED [Illegible]	
82. SIGNATURE OF DECEASED [Illegible]		83. SIGNATURE OF DECEASED [Illegible]		84. SIGNATURE OF DECEASED [Illegible]	
85. SIGNATURE OF DECEASED [Illegible]		86. SIGNATURE OF DECEASED [Illegible]		87. SIGNATURE OF DECEASED [Illegible]	
88. SIGNATURE OF DECEASED [Illegible]		89. SIGNATURE OF DECEASED [Illegible]		90. SIGNATURE OF DECEASED [Illegible]	
91. SIGNATURE OF DECEASED [Illegible]		92. SIGNATURE OF DECEASED [Illegible]		93. SIGNATURE OF DECEASED [Illegible]	
94. SIGNATURE OF DECEASED [Illegible]		95. SIGNATURE OF DECEASED [Illegible]		96. SIGNATURE OF DECEASED [Illegible]	
97. SIGNATURE OF DECEASED [Illegible]		98. SIGNATURE OF DECEASED [Illegible]		99. SIGNATURE OF DECEASED [Illegible]	
100. SIGNATURE OF DECEASED [Illegible]		101. SIGNATURE OF DECEASED [Illegible]		102. SIGNATURE OF DECEASED [Illegible]	

PROVIDED BY THE

BUREAU Y. 2

AUG 8 1956

RECEIVED

8015

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 31 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2610 Wycliffe Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First BASCOM Middle B. Last GARDNER				4. DATE OF DEATH Month August Day 19 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/9/86	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Western Md. Dairy		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Cyrus Gardner				14. MOTHER'S MAIDEN NAME Rebecca Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW-I				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT CLIN.REC.VET.ADM.HOSP., FT. HOWARD, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 1 Month			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from July 19 , 19 56 , to August 19 , 19 56 , and that death occurred at 5:03 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Md. DATE SIGNED 8/19/56							
ACTUAL SIGNATURE Rolando Ponce de Leon				M.D. VAH, Fort Howard, Maryland			
PHYSICIAN'S NAME (Type) ROLANDO O PONCE DE LEON, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 22, 56		22c. NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 1505 Harford Rd. Baltimore, Maryland		24a. REC'D BY REGISTRAR DATE AUG 20 1956	
24b. REGISTRAR'S SIGNATURE Dawson Lauer							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07985

8016 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND COUNTY 1 Barb			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN COCKEYSVILLE		LENGTH OF STAY (in this place) 15 YEARS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE (29)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 MASONIC HOME				STREET ADDRESS (If rural give location) 738 BEECHFIELD AVE 1			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) HATTIE LEE GARNETTE				4. DATE OF DEATH (Month) (Day) (Year) AUG 4 1956			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH 10/9/1864	9. AGE last birthday 91 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BOWLING GREEN, VA		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME WILLIAM F SMOOT				14. MOTHER'S MAIDEN NAME ADELIA E SMOOT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS Frank L. Smith Jr. Cockeysville Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						10 yrs.	
422.1 IMMEDIATE CAUSE (A) Candida Vascular Disease							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 76, to 19 56, that I last saw the deceased alive on 8/3, 19 56, and that death occurred at 9:30 A.M. from the causes and on the date stated above.							
SIGNATURE Walter T. Lees				ADDRESS (Street, city, town, state) Cockeysville Md.		DATE SIGNED 8/4/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 8-7-56		NAME OF CEMETERY OR CREMATORY Meadowridge		LOCATION (City, town, or county) BALTO Md (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Frank Smith		25. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Inc 1217 St Paul St.		ADDRESS	
DATE AUG 6 1956							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8017

CERTIFICATE OF DEATH

Reg. Dist. **07986**

1. PLACE OF DEATH a. COUNTY Balto. Countym Md. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Rural			c. LENGTH OF STAY IN lb 3 mo.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md.			d. STREET ADDRESS 1007 E. Lombard St.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CIRA Middle CARDIA Last PALEO				4. DATE OF DEATH Month August Day 28 Year 1956			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1879		9. AGE (In years last birthday) yrs. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Palermo, Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Rocco Teresi				14. MOTHER'S MAIDEN NAME Marie Pace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary Pastore		Address 1007 E. Lombard St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident (Thrombosis) 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 56 , to May 27 , 19 56 , that I last saw the deceased alive on May 27 , 19 56 , and that death occurred at 11 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4605 EDMONDSON AVE DATE SIGNED 8/19/56							
ACTUAL SIGNATURE Cliff Ratliff, Jr. M.D.				PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Aug. 31, 1956		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer/		22d. LOCATION (City, town, or county) (State) Belair Rd. & Moravia Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank Della Noce				ADDRESS 322 S. High St.		24a. REC'D BY REGISTRAR DATE AUG 31 1956	
24b. REGISTRAR'S SIGNATURE J. E. Harry							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JAMES EARL RAY		35		M		W		1921		MEMPHIS		TENNESSEE		UNITED STATES				APRIL 4, 1968		MEMPHIS		TENNESSEE		UNITED STATES			
FATHER'S NAME		MOTHER'S NAME		MARRIAGE DATE		MARRIAGE PLACE		MARRIAGE CITY		MARRIAGE STATE		MARRIAGE COUNTRY		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.		FILE NO.	
JAMES EARL RAY		JAMES EARL RAY												HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL		1000		1000		1000	
DATE OF INTERVIEW		INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF NOTARY		SIGNATURE OF SHERIFF		SIGNATURE OF DEPUTY SHERIFF		SIGNATURE OF JAILER		SIGNATURE OF WARDEN	
APRIL 10, 1968		JAMES EARL RAY																									

BUREAU V. 1

AUG 31 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
2
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8918
CERTIFICATE OF DEATH

07987
20

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 901 St. Agnes Lane		d. STREET ADDRESS 901 St. Agnes Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Gebhart		4. DATE OF DEATH Month Aug. Day 7 Year 19 56	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1867
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.	11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Christian Otto		14. MOTHER'S MAIDEN NAME Matilda	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs William Monahan, 901 St. Agnes Lane.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of uterus 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility			INTERVAL BETWEEN ONSET AND DEATH 10 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 6, 19 56 to August 7, 19 56 , that I last saw the deceased alive on August 6, 19 56 , and that death occurred at 4:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Melvin N. Borden M.D.		ADDRESS (Street, city or town, state) 5000 Old Frederick Rd DATE SIGNED 8/8/56	
PHYSICIAN'S NAME (Type) Melvin N. BORDEN		Baltimore 29, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 10/56	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witke		24a. REG'D BY REGISTRAR AUG 10 1956	
ADDRESS 4101 Edmondson Ave.		24b. REGISTRAR'S SIGNATURE V. E. Harry	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

8012

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED JAMES H. HARRIS		DATE OF BIRTH JAN 15 1895		PLACE OF BIRTH BALTIMORE, MD.	
MARRIED		OCCUPATION LABORER		EDUCATION HIGH SCHOOL	
RESIDENCE 201 E. L. A. R. A. HOME		DATE OF DEATH AUG 10 1956		PLACE OF DEATH BALTIMORE, MD.	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		MEDICAL ATTENDANCE YES	
DATE OF DEATH AUG 10 1956		TIME OF DEATH 10:00 AM		PLACE OF DEATH BALTIMORE, MD.	
NAME OF DECEASED JAMES H. HARRIS		DATE OF BIRTH JAN 15 1895		PLACE OF BIRTH BALTIMORE, MD.	
MARRIED		OCCUPATION LABORER		EDUCATION HIGH SCHOOL	
RESIDENCE 201 E. L. A. R. A. HOME		DATE OF DEATH AUG 10 1956		PLACE OF DEATH BALTIMORE, MD.	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		MEDICAL ATTENDANCE YES	
DATE OF DEATH AUG 10 1956		TIME OF DEATH 10:00 AM		PLACE OF DEATH BALTIMORE, MD.	

BUREAU V. 3

AUG 10 1956

RECEIVED

James H. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8019

CERTIFICATE OF DEATH

07988

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 4Y10MT20DYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
				d. STREET ADDRESS 234 S. Highland Ave.			
3. NAME OF DECEASED (Type or print) First Joseph Middle Last Genevese Sr.				4. DATE OF DEATH Month August Day 28 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 8, 1871	
9. AGE (In years last birthday) 84 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith Helper		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 84 yrs.	
11. BIRTHPLACE (State or foreign country) Italy				12. CITIZEN OF WHAT COUNTRY? Italy			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records of Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA of the liver. 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardio-vascular disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 10, 1959 to August 28, 1956 that I last saw the deceased alive on August 28, 1956 , and that death occurred at 1:30PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Spella Washler				M.D. Spring Grove State Hospital			
PHYSICIAN'S NAME (Type) Catonsville, 28, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 31, 1956		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost				24a. REC'D BY REGISTRAR Aug 31 1956		24b. REGISTRAR'S SIGNATURE F. G. Harry	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		DATE OF BIRTH 12-1-28		PLACE OF BIRTH MOBILE, ALABAMA	
SEX MALE		RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION None		MARRIAGE None		RELIGION None	
DATE OF DEATH 4-4-68		PLACE OF DEATH MEMPHIS, TENNESSEE		CAUSE OF DEATH SHOOTING	
MANNER OF DEATH Suicide		DISEASE OR INJURY None		TREATMENT None	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None		SIGNATURE OF PHYSICIAN None	
DATE OF SIGNATURE None		DATE OF SIGNATURE None		DATE OF SIGNATURE None	
PLACE OF SIGNATURE None		PLACE OF SIGNATURE None		PLACE OF SIGNATURE None	
NAME OF PHYSICIAN None		NAME OF WITNESS None		NAME OF DECEASED None	
ADDRESS OF PHYSICIAN None		ADDRESS OF WITNESS None		ADDRESS OF DECEASED None	
CITY OF PHYSICIAN None		CITY OF WITNESS None		CITY OF DECEASED None	
STATE OF PHYSICIAN None		STATE OF WITNESS None		STATE OF DECEASED None	
COUNTRY OF PHYSICIAN None		COUNTRY OF WITNESS None		COUNTRY OF DECEASED None	
NAME OF DECEASED JAMES EARL RAY		DATE OF BIRTH 12-1-28		PLACE OF BIRTH MOBILE, ALABAMA	
SEX MALE		RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION None		MARRIAGE None		RELIGION None	
DATE OF DEATH 4-4-68		PLACE OF DEATH MEMPHIS, TENNESSEE		CAUSE OF DEATH SHOOTING	
MANNER OF DEATH Suicide		DISEASE OR INJURY None		TREATMENT None	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None		SIGNATURE OF PHYSICIAN None	
DATE OF SIGNATURE None		DATE OF SIGNATURE None		DATE OF SIGNATURE None	
PLACE OF SIGNATURE None		PLACE OF SIGNATURE None		PLACE OF SIGNATURE None	
NAME OF PHYSICIAN None		NAME OF WITNESS None		NAME OF DECEASED None	
ADDRESS OF PHYSICIAN None		ADDRESS OF WITNESS None		ADDRESS OF DECEASED None	
CITY OF PHYSICIAN None		CITY OF WITNESS None		CITY OF DECEASED None	
STATE OF PHYSICIAN None		STATE OF WITNESS None		STATE OF DECEASED None	
COUNTRY OF PHYSICIAN None		COUNTRY OF WITNESS None		COUNTRY OF DECEASED None	

BUREAU OF VITAL RECORDS

AUG 31 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8020

CERTIFICATE OF DEATH

Reg. Dist. No. 079890

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK, MD. 10X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Rosalia GENS		4. DATE OF DEATH Month 8 Day 31 Year 1956	
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1875
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN FALLON		14. MOTHER'S MAIDEN NAME MARY SCHILL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT A. FALLON		Address 4619 FRANK FORD AVE BALTO MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-3-44 to 8-31-56 , that I last saw the deceased alive on 8-31-56 , 19 56 , and that death occurred at 10:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David Edwards MD		DATE SIGNED 8-31-56	
PHYSICIAN'S NAME (Type) Spring Grove Hospital		DAVID EDWARDS MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-4-56	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) BALTO, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		24a. REC'D BY REGISTRAR SEP 4 1956	
ADDRESS 5305 Harford Rd		24b. REGISTRAR'S SIGNATURE T. C. Barry	

CERTIFICATE OF DEATH

2020

1. NAME OF DECEASED ROBERT		2. SEX M		3. AGE 45		4. RACE W		5. PLACE OF BIRTH BALTIMORE	
6. DATE OF DEATH SEP 4 1956		7. TIME OF DEATH 10:00 AM		8. PLACE OF DEATH HOME		9. CAUSE OF DEATH HEART DISEASE		10. MANNER OF DEATH NATURAL	
11. SIGNATURE OF PHYSICIAN J. H. ROBERT		12. SIGNATURE OF DECEASED ROBERT		13. SIGNATURE OF WITNESS J. H. ROBERT		14. SIGNATURE OF DECEASED ROBERT		15. SIGNATURE OF WITNESS J. H. ROBERT	
16. SIGNATURE OF DECEASED ROBERT		17. SIGNATURE OF WITNESS J. H. ROBERT		18. SIGNATURE OF DECEASED ROBERT		19. SIGNATURE OF WITNESS J. H. ROBERT		20. SIGNATURE OF DECEASED ROBERT	
21. SIGNATURE OF DECEASED ROBERT		22. SIGNATURE OF WITNESS J. H. ROBERT		23. SIGNATURE OF DECEASED ROBERT		24. SIGNATURE OF WITNESS J. H. ROBERT		25. SIGNATURE OF DECEASED ROBERT	
26. SIGNATURE OF DECEASED ROBERT		27. SIGNATURE OF WITNESS J. H. ROBERT		28. SIGNATURE OF DECEASED ROBERT		29. SIGNATURE OF WITNESS J. H. ROBERT		30. SIGNATURE OF DECEASED ROBERT	
31. SIGNATURE OF DECEASED ROBERT		32. SIGNATURE OF WITNESS J. H. ROBERT		33. SIGNATURE OF DECEASED ROBERT		34. SIGNATURE OF WITNESS J. H. ROBERT		35. SIGNATURE OF DECEASED ROBERT	
36. SIGNATURE OF DECEASED ROBERT		37. SIGNATURE OF WITNESS J. H. ROBERT		38. SIGNATURE OF DECEASED ROBERT		39. SIGNATURE OF WITNESS J. H. ROBERT		40. SIGNATURE OF DECEASED ROBERT	
41. SIGNATURE OF DECEASED ROBERT		42. SIGNATURE OF WITNESS J. H. ROBERT		43. SIGNATURE OF DECEASED ROBERT		44. SIGNATURE OF WITNESS J. H. ROBERT		45. SIGNATURE OF DECEASED ROBERT	
46. SIGNATURE OF DECEASED ROBERT		47. SIGNATURE OF WITNESS J. H. ROBERT		48. SIGNATURE OF DECEASED ROBERT		49. SIGNATURE OF WITNESS J. H. ROBERT		50. SIGNATURE OF DECEASED ROBERT	
51. SIGNATURE OF DECEASED ROBERT		52. SIGNATURE OF WITNESS J. H. ROBERT		53. SIGNATURE OF DECEASED ROBERT		54. SIGNATURE OF WITNESS J. H. ROBERT		55. SIGNATURE OF DECEASED ROBERT	
56. SIGNATURE OF DECEASED ROBERT		57. SIGNATURE OF WITNESS J. H. ROBERT		58. SIGNATURE OF DECEASED ROBERT		59. SIGNATURE OF WITNESS J. H. ROBERT		60. SIGNATURE OF DECEASED ROBERT	
61. SIGNATURE OF DECEASED ROBERT		62. SIGNATURE OF WITNESS J. H. ROBERT		63. SIGNATURE OF DECEASED ROBERT		64. SIGNATURE OF WITNESS J. H. ROBERT		65. SIGNATURE OF DECEASED ROBERT	
66. SIGNATURE OF DECEASED ROBERT		67. SIGNATURE OF WITNESS J. H. ROBERT		68. SIGNATURE OF DECEASED ROBERT		69. SIGNATURE OF WITNESS J. H. ROBERT		70. SIGNATURE OF DECEASED ROBERT	
71. SIGNATURE OF DECEASED ROBERT		72. SIGNATURE OF WITNESS J. H. ROBERT		73. SIGNATURE OF DECEASED ROBERT		74. SIGNATURE OF WITNESS J. H. ROBERT		75. SIGNATURE OF DECEASED ROBERT	
76. SIGNATURE OF DECEASED ROBERT		77. SIGNATURE OF WITNESS J. H. ROBERT		78. SIGNATURE OF DECEASED ROBERT		79. SIGNATURE OF WITNESS J. H. ROBERT		80. SIGNATURE OF DECEASED ROBERT	
81. SIGNATURE OF DECEASED ROBERT		82. SIGNATURE OF WITNESS J. H. ROBERT		83. SIGNATURE OF DECEASED ROBERT		84. SIGNATURE OF WITNESS J. H. ROBERT		85. SIGNATURE OF DECEASED ROBERT	
86. SIGNATURE OF DECEASED ROBERT		87. SIGNATURE OF WITNESS J. H. ROBERT		88. SIGNATURE OF DECEASED ROBERT		89. SIGNATURE OF WITNESS J. H. ROBERT		90. SIGNATURE OF DECEASED ROBERT	
91. SIGNATURE OF DECEASED ROBERT		92. SIGNATURE OF WITNESS J. H. ROBERT		93. SIGNATURE OF DECEASED ROBERT		94. SIGNATURE OF WITNESS J. H. ROBERT		95. SIGNATURE OF DECEASED ROBERT	
96. SIGNATURE OF DECEASED ROBERT		97. SIGNATURE OF WITNESS J. H. ROBERT		98. SIGNATURE OF DECEASED ROBERT		99. SIGNATURE OF WITNESS J. H. ROBERT		100. SIGNATURE OF DECEASED ROBERT	

BUREAU V.I.B.

SEP 5 1956

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8021

CERTIFICATE OF DEATH

07990

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Towson Nursing Home</i>		d. STREET ADDRESS <i>301 W. Chesapeake Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Dorothea J. Gettier</i> First Middle Last		4. DATE OF DEATH <i>August 1,</i> Month Day Year <i>19 56</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/20/ '76</i>
9. AGE (In years last birthday) <i>79</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At home</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Balto., Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S</i>	
13. FATHER'S NAME <i>Ferdinand Schatz</i>		14. MOTHER'S MAIDEN NAME <i>Dorothea Angelka</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. Leroy Hill, 543 Valleyview Rd 4</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>carcinomatosis</i> DUE TO <i>carcinoma of the ovary</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>175x</i> (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 31, 1956</i> to <i>Aug 1, 1956</i> , that I last saw the deceased alive on <i>Aug 1, 1956</i> , and that death occurred at <i>1a</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Robert Mazer</i> M.D.		PHYSICIAN'S NAME (Type) <i>Robert Mazer</i> 5716 Beechdale Avenue, Baltimore <i>ru</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/31/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood</i>	22d. LOCATION (City, town, or county) (State) <i>Balto., Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>L J Ruck, 5305 Harford Rd</i>		24a. REC'D BY REGISTRAR DATE <i>8-1-56</i>	24b. REGISTRAR'S SIGNATURE <i>Mabel C. Gray</i>

CERTIFICATE OF DEATH

8021

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN		19. SIGNATURE OF CLERGYMAN		20. SIGNATURE OF BURIAL OFFICIAL		21. SIGNATURE OF FUNERAL HOME		22. SIGNATURE OF CEMETERY		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF SUPERVISOR	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF CLERGYMAN		28. SIGNATURE OF BURIAL OFFICIAL		29. SIGNATURE OF FUNERAL HOME		30. SIGNATURE OF CEMETERY		31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF SUPERVISOR	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF NEXT OF KIN		35. SIGNATURE OF CLERGYMAN		36. SIGNATURE OF BURIAL OFFICIAL		37. SIGNATURE OF FUNERAL HOME		38. SIGNATURE OF CEMETERY		39. SIGNATURE OF INTERVIEWER		40. SIGNATURE OF SUPERVISOR	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF CLERGYMAN		44. SIGNATURE OF BURIAL OFFICIAL		45. SIGNATURE OF FUNERAL HOME		46. SIGNATURE OF CEMETERY		47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF SUPERVISOR	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF NEXT OF KIN		51. SIGNATURE OF CLERGYMAN		52. SIGNATURE OF BURIAL OFFICIAL		53. SIGNATURE OF FUNERAL HOME		54. SIGNATURE OF CEMETERY		55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF SUPERVISOR	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF NEXT OF KIN		59. SIGNATURE OF CLERGYMAN		60. SIGNATURE OF BURIAL OFFICIAL		61. SIGNATURE OF FUNERAL HOME		62. SIGNATURE OF CEMETERY		63. SIGNATURE OF INTERVIEWER		64. SIGNATURE OF SUPERVISOR	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF NEXT OF KIN		67. SIGNATURE OF CLERGYMAN		68. SIGNATURE OF BURIAL OFFICIAL		69. SIGNATURE OF FUNERAL HOME		70. SIGNATURE OF CEMETERY		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF SUPERVISOR	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF NEXT OF KIN		75. SIGNATURE OF CLERGYMAN		76. SIGNATURE OF BURIAL OFFICIAL		77. SIGNATURE OF FUNERAL HOME		78. SIGNATURE OF CEMETERY		79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF SUPERVISOR	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF CLERGYMAN		84. SIGNATURE OF BURIAL OFFICIAL		85. SIGNATURE OF FUNERAL HOME		86. SIGNATURE OF CEMETERY		87. SIGNATURE OF INTERVIEWER		88. SIGNATURE OF SUPERVISOR	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF NEXT OF KIN		91. SIGNATURE OF CLERGYMAN		92. SIGNATURE OF BURIAL OFFICIAL		93. SIGNATURE OF FUNERAL HOME		94. SIGNATURE OF CEMETERY		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF SUPERVISOR	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF NEXT OF KIN		99. SIGNATURE OF CLERGYMAN		100. SIGNATURE OF BURIAL OFFICIAL		101. SIGNATURE OF FUNERAL HOME		102. SIGNATURE OF CEMETERY		103. SIGNATURE OF INTERVIEWER		104. SIGNATURE OF SUPERVISOR	
105. SIGNATURE OF DECEASED		106. SIGNATURE OF NEXT OF KIN		107. SIGNATURE OF CLERGYMAN		108. SIGNATURE OF BURIAL OFFICIAL		109. SIGNATURE OF FUNERAL HOME		110. SIGNATURE OF CEMETERY		111. SIGNATURE OF INTERVIEWER		112. SIGNATURE OF SUPERVISOR	
113. SIGNATURE OF DECEASED		114. SIGNATURE OF NEXT OF KIN		115. SIGNATURE OF CLERGYMAN		116. SIGNATURE OF BURIAL OFFICIAL		117. SIGNATURE OF FUNERAL HOME		118. SIGNATURE OF CEMETERY		119. SIGNATURE OF INTERVIEWER		120. SIGNATURE OF SUPERVISOR	
121. SIGNATURE OF DECEASED		122. SIGNATURE OF NEXT OF KIN		123. SIGNATURE OF CLERGYMAN		124. SIGNATURE OF BURIAL OFFICIAL		125. SIGNATURE OF FUNERAL HOME		126. SIGNATURE OF CEMETERY		127. SIGNATURE OF INTERVIEWER		128. SIGNATURE OF SUPERVISOR	
129. SIGNATURE OF DECEASED		130. SIGNATURE OF NEXT OF KIN		131. SIGNATURE OF CLERGYMAN		132. SIGNATURE OF BURIAL OFFICIAL		133. SIGNATURE OF FUNERAL HOME		134. SIGNATURE OF CEMETERY		135. SIGNATURE OF INTERVIEWER		136. SIGNATURE OF SUPERVISOR	
137. SIGNATURE OF DECEASED		138. SIGNATURE OF NEXT OF KIN		139. SIGNATURE OF CLERGYMAN		140. SIGNATURE OF BURIAL OFFICIAL		141. SIGNATURE OF FUNERAL HOME		142. SIGNATURE OF CEMETERY		143. SIGNATURE OF INTERVIEWER		144. SIGNATURE OF SUPERVISOR	
145. SIGNATURE OF DECEASED		146. SIGNATURE OF NEXT OF KIN		147. SIGNATURE OF CLERGYMAN		148. SIGNATURE OF BURIAL OFFICIAL		149. SIGNATURE OF FUNERAL HOME		150. SIGNATURE OF CEMETERY		151. SIGNATURE OF INTERVIEWER		152. SIGNATURE OF SUPERVISOR	
153. SIGNATURE OF DECEASED		154. SIGNATURE OF NEXT OF KIN		155. SIGNATURE OF CLERGYMAN		156. SIGNATURE OF BURIAL OFFICIAL		157. SIGNATURE OF FUNERAL HOME		158. SIGNATURE OF CEMETERY		159. SIGNATURE OF INTERVIEWER		160. SIGNATURE OF SUPERVISOR	
161. SIGNATURE OF DECEASED		162. SIGNATURE OF NEXT OF KIN		163. SIGNATURE OF CLERGYMAN		164. SIGNATURE OF BURIAL OFFICIAL		165. SIGNATURE OF FUNERAL HOME		166. SIGNATURE OF CEMETERY		167. SIGNATURE OF INTERVIEWER		168. SIGNATURE OF SUPERVISOR	
169. SIGNATURE OF DECEASED		170. SIGNATURE OF NEXT OF KIN		171. SIGNATURE OF CLERGYMAN		172. SIGNATURE OF BURIAL OFFICIAL		173. SIGNATURE OF FUNERAL HOME		174. SIGNATURE OF CEMETERY		175. SIGNATURE OF INTERVIEWER		176. SIGNATURE OF SUPERVISOR	
177. SIGNATURE OF DECEASED		178. SIGNATURE OF NEXT OF KIN		179. SIGNATURE OF CLERGYMAN		180. SIGNATURE OF BURIAL OFFICIAL		181. SIGNATURE OF FUNERAL HOME		182. SIGNATURE OF CEMETERY		183. SIGNATURE OF INTERVIEWER		184. SIGNATURE OF SUPERVISOR	
185. SIGNATURE OF DECEASED		186. SIGNATURE OF NEXT OF KIN		187. SIGNATURE OF CLERGYMAN		188. SIGNATURE OF BURIAL OFFICIAL		189. SIGNATURE OF FUNERAL HOME		190. SIGNATURE OF CEMETERY		191. SIGNATURE OF INTERVIEWER		192. SIGNATURE OF SUPERVISOR	
193. SIGNATURE OF DECEASED		194. SIGNATURE OF NEXT OF KIN		195. SIGNATURE OF CLERGYMAN		196. SIGNATURE OF BURIAL OFFICIAL		197. SIGNATURE OF FUNERAL HOME		198. SIGNATURE OF CEMETERY		199. SIGNATURE OF INTERVIEWER		200. SIGNATURE OF SUPERVISOR	

BUREAU V. 8

AUG 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07991
30

8922

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b four years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		d. STREET ADDRESS 8720 Old Harford Road	
3. NAME OF DECEASED (Type or print) First Lon Middle Gilliam Last Gilliam		4. DATE OF DEATH Month August Day 28 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 3, 1900
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) gardener		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lon Holland Gilliam		14. MOTHER'S MAIDEN NAME Selia Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Pauline Rempel - 8720 Old Harford Rd. - 14		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic mitral valvular disease 410X DUE TO Old Rheumatic disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 025X (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Paralysis of Brain due to Central Nervous system		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 29, 1952 , to Aug. 28, 1956 , that I last saw the deceased alive on Aug. 28, 1956 , and that death occurred at 7:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 8-28-56			
ACTUAL SIGNATURE Ellis S. Margolin M.D.		PHYSICIAN'S NAME (Type) Ellis S. Margolin, M. D.	
22a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL		22b. DATE THEREOF Aug 31, 1956	
22c. NAME OF CEMETERY OR CREMATORY Monland Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. ... ADDRESS 8802 Harford Rd		24a. REC'D BY REGISTRAR AUG 31 1956 24b. REGISTRAR'S SIGNATURE T. E. Harry	

BUREAU V. 81

1956 31 AUG

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 30

8723

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Baltimore Md.</u> COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN IB <u>8yrlmt15days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>C.</u> Last <u>Goldsborough</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>13,</u> Year <u>19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1898</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u>57</u> Days <u>13</u> Hours <u>13</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph W. Goldsborough</u>		14. MOTHER'S MAIDEN NAME <u>Mella A. Yates</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Arteriosclerotic cardiovascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac decompensation</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. p.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 11, 1956</u> , to <u>Aug. 13, 1956</u> , that I last saw the deceased alive on <u>Aug. 13, 1956</u> , and that death occurred at <u>6:50a</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Stella Wachslar</u>		M.D. <u>SPRING GROVE STATE HOSPITAL 8-14-56</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>--</u>	22c. NAME OF CEMETERY OR CREMATORY <u>U. Of M.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>VS A15 (4) 15M 9/55</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
24b. REGISTRAR'S SIGNATURE <u>Victor Harry</u>		<u>E.F.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07993

8:24

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) nr. Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6421 Murray Hill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HELEN Middle M. Last GOOD		4. DATE OF DEATH Month Aug. Day 10 Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1890
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George W. Lawson		14. MOTHER'S MAIDEN NAME Ellen Mahoney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Mr. Charles L. Good - 121 First Ave., Reisters-town			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 9, 1956 to Aug 10, 1956 , that I last saw the deceased alive on Aug 9, 1956 , and that death occurred at 12:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2312 Canton Place DATE SIGNED ACTUAL SIGNATURE Sidore I. Levy M.D. PHYSICIAN'S NAME (Type) Sidore I. Levy			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/14/56	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Stm. J. Tichener & Sons - Balto 17 Md		24a. REC'D BY REGISTRAR DATE 8/13/56	
24b. REGISTRAR'S SIGNATURE Mabel Gray			

CERTIFICATE OF DEATH

3024

1. PLACE OF BIRTH COUNTY		2. PLACE OF DEATH COUNTY	
3. SEX M F		4. AGE YEARS MONTHS DAYS	
5. OCCUPATION		6. CAUSE OF DEATH IMMEDIATE	
7. DATE OF DEATH		8. TIME OF DEATH	
9. PLACE OF DEATH HOSPITAL HOME OTHER		10. NAME OF PHYSICIAN	
11. NAME OF DECEASED		12. NAME OF REPORTER	
13. ADDRESS OF DECEASED		14. ADDRESS OF REPORTER	
15. CITY		16. STATE	
17. ZIP CODE		18. COUNTY	
19. DATE OF BIRTH		20. TIME OF BIRTH	
21. PLACE OF BIRTH		22. NAME OF PHYSICIAN	
23. NAME OF DECEASED		24. NAME OF REPORTER	
25. ADDRESS OF DECEASED		26. ADDRESS OF REPORTER	
27. CITY		28. STATE	
29. ZIP CODE		30. COUNTY	
31. DATE OF BIRTH		32. TIME OF BIRTH	
33. PLACE OF BIRTH		34. NAME OF PHYSICIAN	
35. NAME OF DECEASED		36. NAME OF REPORTER	
37. ADDRESS OF DECEASED		38. ADDRESS OF REPORTER	
39. CITY		40. STATE	
41. ZIP CODE		42. COUNTY	
43. DATE OF BIRTH		44. TIME OF BIRTH	
45. PLACE OF BIRTH		46. NAME OF PHYSICIAN	
47. NAME OF DECEASED		48. NAME OF REPORTER	
49. ADDRESS OF DECEASED		50. ADDRESS OF REPORTER	
51. CITY		52. STATE	
53. ZIP CODE		54. COUNTY	
55. DATE OF BIRTH		56. TIME OF BIRTH	
57. PLACE OF BIRTH		58. NAME OF PHYSICIAN	
59. NAME OF DECEASED		60. NAME OF REPORTER	
61. ADDRESS OF DECEASED		62. ADDRESS OF REPORTER	
63. CITY		64. STATE	
65. ZIP CODE		66. COUNTY	
67. DATE OF BIRTH		68. TIME OF BIRTH	
69. PLACE OF BIRTH		70. NAME OF PHYSICIAN	
71. NAME OF DECEASED		72. NAME OF REPORTER	
73. ADDRESS OF DECEASED		74. ADDRESS OF REPORTER	
75. CITY		76. STATE	
77. ZIP CODE		78. COUNTY	
79. DATE OF BIRTH		80. TIME OF BIRTH	
81. PLACE OF BIRTH		82. NAME OF PHYSICIAN	
83. NAME OF DECEASED		84. NAME OF REPORTER	
85. ADDRESS OF DECEASED		86. ADDRESS OF REPORTER	
87. CITY		88. STATE	
89. ZIP CODE		90. COUNTY	
91. DATE OF BIRTH		92. TIME OF BIRTH	
93. PLACE OF BIRTH		94. NAME OF PHYSICIAN	
95. NAME OF DECEASED		96. NAME OF REPORTER	
97. ADDRESS OF DECEASED		98. ADDRESS OF REPORTER	
99. CITY		100. STATE	
101. ZIP CODE		102. COUNTY	
103. DATE OF BIRTH		104. TIME OF BIRTH	
105. PLACE OF BIRTH		106. NAME OF PHYSICIAN	
107. NAME OF DECEASED		108. NAME OF REPORTER	
109. ADDRESS OF DECEASED		110. ADDRESS OF REPORTER	
111. CITY		112. STATE	
113. ZIP CODE		114. COUNTY	
115. DATE OF BIRTH		116. TIME OF BIRTH	
117. PLACE OF BIRTH		118. NAME OF PHYSICIAN	
119. NAME OF DECEASED		120. NAME OF REPORTER	
121. ADDRESS OF DECEASED		122. ADDRESS OF REPORTER	
123. CITY		124. STATE	
125. ZIP CODE		126. COUNTY	
127. DATE OF BIRTH		128. TIME OF BIRTH	
129. PLACE OF BIRTH		130. NAME OF PHYSICIAN	
131. NAME OF DECEASED		132. NAME OF REPORTER	
133. ADDRESS OF DECEASED		134. ADDRESS OF REPORTER	
135. CITY		136. STATE	
137. ZIP CODE		138. COUNTY	
139. DATE OF BIRTH		140. TIME OF BIRTH	
141. PLACE OF BIRTH		142. NAME OF PHYSICIAN	
143. NAME OF DECEASED		144. NAME OF REPORTER	
145. ADDRESS OF DECEASED		146. ADDRESS OF REPORTER	
147. CITY		148. STATE	
149. ZIP CODE		150. COUNTY	
151. DATE OF BIRTH		152. TIME OF BIRTH	
153. PLACE OF BIRTH		154. NAME OF PHYSICIAN	
155. NAME OF DECEASED		156. NAME OF REPORTER	
157. ADDRESS OF DECEASED		158. ADDRESS OF REPORTER	
159. CITY		160. STATE	
161. ZIP CODE		162. COUNTY	
163. DATE OF BIRTH		164. TIME OF BIRTH	
165. PLACE OF BIRTH		166. NAME OF PHYSICIAN	
167. NAME OF DECEASED		168. NAME OF REPORTER	
169. ADDRESS OF DECEASED		170. ADDRESS OF REPORTER	
171. CITY		172. STATE	
173. ZIP CODE		174. COUNTY	
175. DATE OF BIRTH		176. TIME OF BIRTH	
177. PLACE OF BIRTH		178. NAME OF PHYSICIAN	
179. NAME OF DECEASED		180. NAME OF REPORTER	
181. ADDRESS OF DECEASED		182. ADDRESS OF REPORTER	
183. CITY		184. STATE	
185. ZIP CODE		186. COUNTY	
187. DATE OF BIRTH		188. TIME OF BIRTH	
189. PLACE OF BIRTH		190. NAME OF PHYSICIAN	
191. NAME OF DECEASED		192. NAME OF REPORTER	
193. ADDRESS OF DECEASED		194. ADDRESS OF REPORTER	
195. CITY		196. STATE	
197. ZIP CODE		198. COUNTY	
199. DATE OF BIRTH		200. TIME OF BIRTH	

BUREAU V. 2

AUG 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8025

CERTIFICATE OF DEATH

07995.44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 3801 Edmondson Avenue				3. NAME OF DECEASED (Type or print) First THOMAS Middle G Last GREEN			
4. DATE OF DEATH Month August Day 20 Year 19 56				5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 5/3/25				9. AGE (In years last birthday) 31 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender				10b. KIND OF BUSINESS OR INDUSTRY Tavern			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME J. Harry Green				14. MOTHER'S MAIDEN NAME Vera M. Flynn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII				16. SOCIAL SECURITY NO. 218-16-1697			
17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER COMA 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CIRRHOSIS LIVER DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 24 HOURS UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from August 16 , 19 56 , to August 20 , 19 56 , and that death occurred at 4:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Fort Howard, Md. DATE SIGNED 8/20/56							
ACTUAL SIGNATURE <i>William E. Hill</i>				PHYSICIAN'S NAME (Type) WILLIAM E. HILL, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 23 1956		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. Miller Lamoreau</i>				24a. REC'D BY REGISTRAR Aug 23 1956			
24b. REGISTRAR'S SIGNATURE <i>Dawson L. Farley</i>				1510 Liberty Heights Avenue, Baltimore, Md.			

CERTIFICATE OF DEATH

1955

DATE OF BIRTH		DATE OF DEATH	
JAN 1 1900		JAN 1 1955	
PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
A FULL CITIZEN		A FULL CITIZEN	
YES		YES	
MARRIED		MARRIED	
YES		YES	
NAME OF SPOUSE		NAME OF SPOUSE	
J. HENRY GREEN		J. HENRY GREEN	
DATE OF MARRIAGE		DATE OF MARRIAGE	
JAN 1 1900		JAN 1 1900	
PLACE OF MARRIAGE		PLACE OF MARRIAGE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
CAUSE OF DEATH		CAUSE OF DEATH	
LIVER CANCER		LIVER CANCER	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
PLACE OF INTERMENT		PLACE OF INTERMENT	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
NAME OF FUNERAL HOME		NAME OF FUNERAL HOME	
J. HENRY GREEN		J. HENRY GREEN	
DATE OF INTERMENT		DATE OF INTERMENT	
JAN 1 1955		JAN 1 1955	
PLACE OF INTERMENT		PLACE OF INTERMENT	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	

BUREAU V. 3

JUN 23 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8926

CERTIFICATE OF DEATH

07996

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CATONSVILLE</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgeway Manor</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u> STREET ADDRESS (If rural give location) <u>5743 Edmondson Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>PAULA H. GRUNER</u> (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 10, 1956</u>	
SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6/29/81</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	9. AGE last birthday <u>75</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>Austria</u> <input checked="" type="checkbox"/>	
13. FATHER'S NAME <u>Johannes Freis</u>		14. MOTHER'S MAIDEN NAME <u>GALL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NONE</u>		17. INFORMANT & ADDRESS <u>Mrs. Herbert H. Gregor, R.F.D.#1 Rockville, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 493X IMMEDIATE CAUSE (A) <u>PNEUMONIA</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>1</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>PARKINSONISM</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not white at work <input type="checkbox"/> White at work <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>May 54</u> , 19 <u>54</u> , to <u>Aug 56</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Aug 19 56</u> , and that death occurred at <u>12:15</u> M, from the causes and on the date stated above.	
SIGNATURE <u>J. Nelson McKay</u>		ADDRESS (Street, city, town, state) <u>6014 Edmondson Ave. P.O. Box 8/10/56</u>	
DATE <u>8/14/56</u>		DATE SIGNED <u>8/10/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	
24. REC'D BY REGISTRAR <u>R. E. Hargis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>	
DATE <u>AUG 14 1956</u>		ADDRESS <u>SILVER SPRING, MD.</u>	

CERTIFICATE OF DEATH

30

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Signature of physician

8. Signature of registrar

9. Date of registration

10. Place of registration

11. Signature of registrar

BUREAU V. 8

AUG 14 1956

RECEIVED

Handwritten signature

INSTRUCTIONS

CERTIFICATE OF DEATH

Reg. Dist. No.

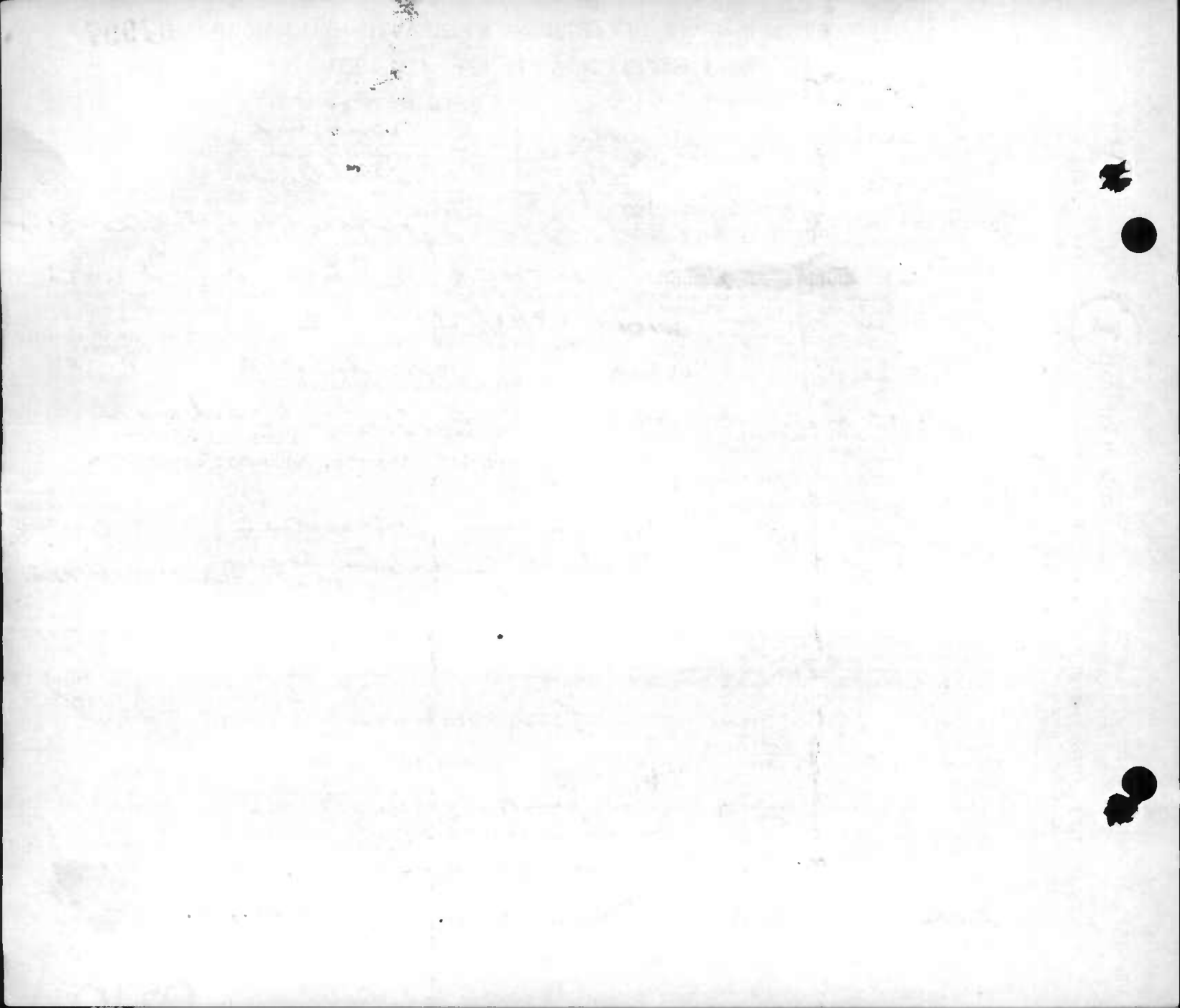
8227

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) 55 TOWN Rural: Towson	LENGTH OF STAY (in this place) 2 yr	CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	3401-4
HOSPITAL OR INSTITUTION OR STREET ADDRESS 01 Eudowood Sanatorium Towson 4, Maryland		STREET ADDRESS (If rural give location) Homerwood apt. Ch. 31st	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
(First) ERNESTINE CHAMBERS (Middle) GUNTHER (Last)		(Month) Aug (Day) 7 (Year) 1956	
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: 9/10/1891
9. AGE last birthday: 74 yrs.		10. AGE last birthday: 1 yr UNDER 1 YEAR 1 yr UNDER 24 HRS.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Housewife		10b. KIND OF BUSINESS OR INDUSTRY: at home	
11. BIRTHPLACE (State or foreign country): Harrisburg PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: William P. Chambers		14. MOTHER'S MAIDEN NAME: Anna E. Drabowicz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: Personal History Hospital Records, Eudowood Sanatorium	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Pulmonary Tuberculosis		3 yr 34 w
Antecedent causes (s) (b) Probable Carcinoma Breast metastasis		6 mos.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from June 9, 1956 to Aug 7, 1956 , that I last saw the deceased alive on Aug 1, 1956 , and that death occurred at 11:10 P.M. from the causes and on the date stated above.		
SIGNATURE Milton B. Green (Degree or title)		DATE SIGNED 8/8/56
ADDRESS Eudowood Sanatorium - Towson 4, Maryland		
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
Burial	8/10/56	Loudon Park Cem.
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	LOCATION (City, town, or county) (State)
	John J. Tiekner & Sons - Balto 17 Md.	Balto., Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

07998

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY 96	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Linthicum Heights	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home in the Pines Conv. Home		STREET ADDRESS (If rural, give location) 107 Hammondsferry Road.	
3. NAME OF DECEASED (Type or Print) Josephine	(First) A	(Middle) Gunther	(Last)
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow	4. DATE OF DEATH 8 17 1956
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife at home		10b. KIND OF BUSINESS OR INDUSTRY	8. DATE OF BIRTH Feb 18, 1877
13. FATHER'S NAME John Kaspar		14. MOTHER'S MAIDEN NAME Mary Vyscocol	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT AND ADDRESS Frank P. Kaspar (brother) 212 W. Franklin St.,		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		9. AGE last birthday 79 yrs	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Acute Myocardial Infarction		2 da.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chs. Hypertensive Cardis-Vasculer Disease		10 yr(?)
(c)		

11. OTHER SIGNIFICANT CONDITIONS Diseases or conditions, if any, contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **4-20**, 19**56**, to **8-17**, 19**56**, that I last saw the deceased alive on **8-17**, 19**56**, and that death occurred at **10:25 P.** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE THEREOF Aug 21, 1956	NAME OF CEMETERY OR CREMATORY Medowridge Cemetery	LOCATION (City, town, or county) Washington Blvd.	(State)
---	-------------------------------------	---	---	---------

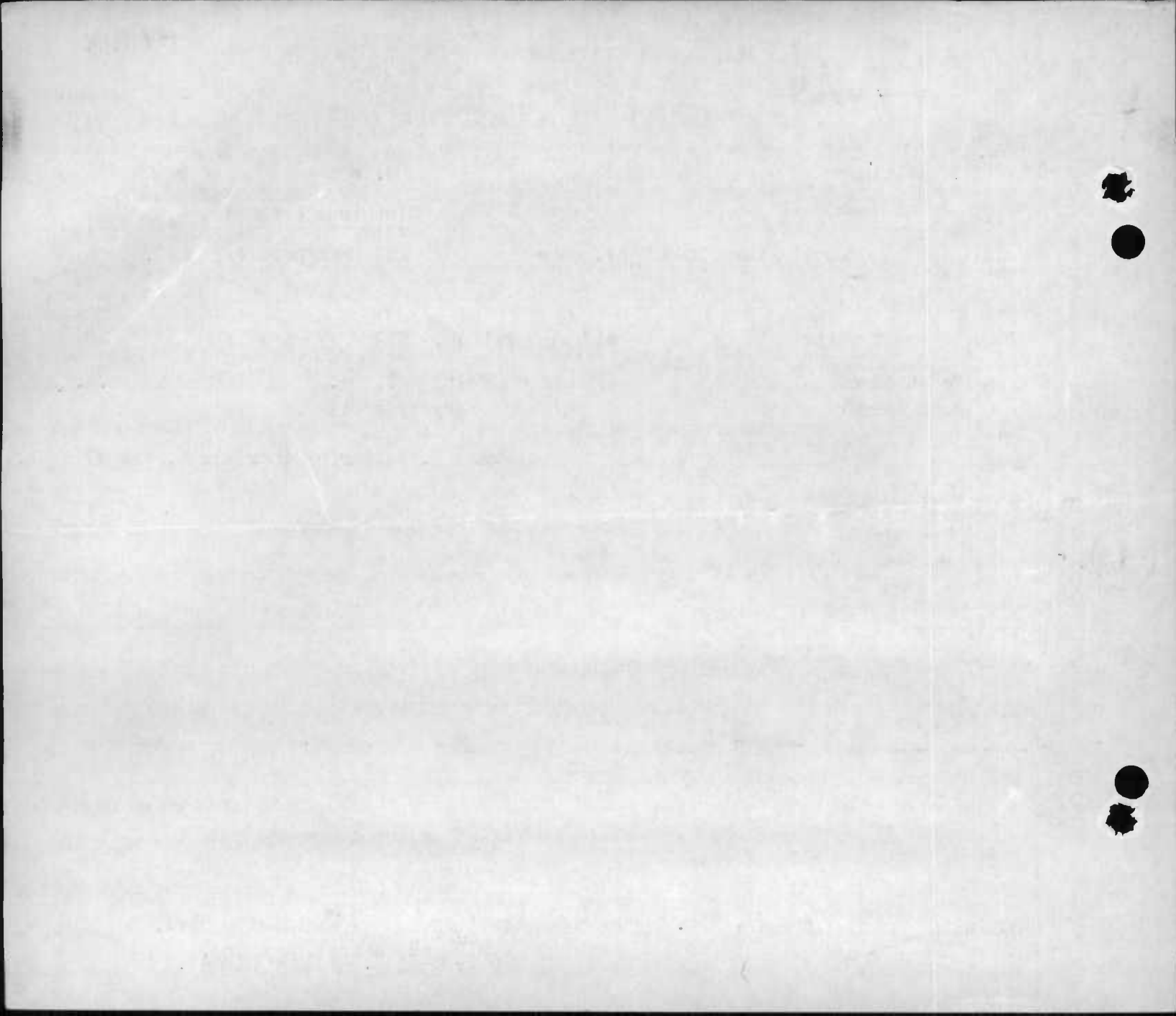
DATE REC'D BY LOCAL REG. Aug 20, 1956	REGISTRAR'S SIGNATURE W. W. Hedrick	24. FUNERAL DIRECTOR Schimunek Funeral Home Inc	ADDRESS 2601-03-05 E. Madison Street.
---	---	---	---

Charles E. Schimunek

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



8029

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) MARY E. GUNTHER			2. DATE OF DEATH Aug. 12, 1956		
3. PLACE OF DEATH: COUNTY Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Balto.		
B. FULL NAME OF HOSPITAL OR INSTITUTION 3728 Milford Mill Rd.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) X		
c. Length of stay in Baltimore Yrs. 00 Mos. 00 Days 00			D. STREET ADDRESS (If rural, give location) 3728 Milford Mill Rd.		
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 16, 1870	9. AGE (In years last birthday) 86	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress (rtd)			10B. KIND OF BUSINESS OR INDUSTRY Shane & Russell, Inc.		11. BIRTHPLACE (State or foreign country) Va.
13. FATHER'S NAME James W. Corbett			14. MOTHER'S MAIDEN NAME Mary A. Marlcachy		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 218-07-9046		
17. INFORMANT			ADDRESS Sgt. Earle Gunther - 3728 Milford Mill Rd		
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 443X ANTECEDENT CAUSES					3 WKS
(A) CEREBRAL THROMBOSIS DUE TO					
(B) CEREBRAL ARTERIO-SCLEROSIS DUE TO					8 YRS
(C) HYPERTENSIVE ART. CARDIOVASC DIS					10-15 YRS
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from FEB 3 1956 to AUGUST 12 1956 , that (I) (we) last saw the deceased alive on AUG 1 1956 , and that death occurred at 12:30 p.m. , from the causes and on the date stated above.					
23A. SIGNATURE Stanley Cohen M.D.		23B. ADDRESS 7306 Liberty Rd Balto		23C. DATE SIGNED 8-12-56	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/15/56	24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.
DATE RECEIVED BY LOCAL REGISTRAR 8/14/56		REGISTRAR'S SIGNATURE A. W. Heedrich		25. FUNERAL DIRECTOR Wm. J. Pickens & Sons -	

M CERTIFICATION

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. If burial or removal, TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8930

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08000

1. PLACE OF DEATH a. COUNTY Edgemere, Balto. Co MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere		c. LENGTH OF STAY IN 1b Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Md. 3Vo 1.4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 425 N. Washington St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alfred T. Middle Gurney Last				4. DATE OF DEATH Month Aug. Day 23 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1903	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Raymond Gurney				14. MOTHER'S MAIDEN NAME Ann ---			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 215-18-7595		17. INFORMANT Address Mrs. Nellie V. Gurney, 425 N. Washington St 31			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lacunar Apoplexy 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 7 hours	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack E Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Jack E Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 27/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Philip Herwig Sons				ADDRESS 2024 Orleans St. 31		24a. REC'D BY REGISTRAR DATE 8/24/56	
				24b. REGISTRAR'S SIGNATURE Dr. Dameson P. Parker			

DATE SIGNED

8-24-56

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF BURIAL		20. SIGNATURE OF CREMATION		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V. E.

MIG 97 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Item 18 et al: 8031 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 08001										
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1615 Gail Road					d. STREET ADDRESS 1615 Gail Road					
3. NAME OF DECEASED (Type or print) First Vera Middle Mae Last Gutowski					4. DATE OF DEATH Month August Day 8 Year 1956					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 10, 1912		9. AGE (In years last birthday) 44 yrs.		
						IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None			16. SOCIAL SECURITY NO. None		17. INFORMANT Stanely Gutowski		Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BARBITURATE POISONING DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 970.2 DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Overdose of sleeping pills							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8-8-56 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) 1615 Gail rd. Baltimore Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Paul F. Guerin					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.					DATE SIGNED 8/9/56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-11-56		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn			22d. LOCATION (City, town, or county) (State) Baltimore Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE James Brzozowski					ADDRESS 1407 Eastern Ave. Rd.		24a. REC'D BY REGISTRAR DATE 8/10/56		24b. REGISTRAR'S SIGNATURE Edith Hurley	

DRAFT

synthesis

1995 11 21 11

ISO 15025

011 8 JES 01 1940 1940 1940 1940 1940

of the

24

BUREAU V. 5

Aug 13 1956

RECEIVED

1957-1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

8052 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

08002

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>IN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt.</u>		c. LENGTH OF STAY IN 1b <u>26 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>17302 N. Nakota Dr.</u>		d. STREET ADDRESS <u>#1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CALLOM</u> Middle <u>HANEY</u> Last <u>HANEY</u>		4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1898</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insulator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Franklin Haney</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Moore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-67-1472</u>	
17. INFORMANT <u>Bessie Haney - as in #1</u>		Address <u>address as in #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Chronic Myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u> <u>10 days</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 9, 1950</u> , to <u>Aug. 25, 1956</u> , that I last saw the deceased alive on <u>Aug. 25, 1956</u> , and that death occurred at <u>10:40 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis N. Tollin</u> M.D.		ADDRESS (Street, city or town, state) <u>6408 North Pt Rd</u> DATE SIGNED <u>8/25/56</u>	
PHYSICIAN'S NAME (Type) <u>Louis N. Tollin</u>		<u>Balto-19-Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-28-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BELAIR MEMORIAL</u>		22d. LOCATION (City, town, or county) (State) <u>BELAIR, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul H. Bradley</u> ADDRESS <u>1414</u>		24a. REC'D BY REGISTRAR <u>Dr. Dawson L. Farber</u> DATE <u>8/27/56</u>	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *JOHN A. HANLEY*

2. SEX: *Male*

3. AGE: *35*

4. DATE OF BIRTH: *1920*

5. PLACE OF BIRTH: *NEW YORK*

6. OCCUPATION: *Engineer*

7. CAUSE OF DEATH: *Heart Disease*

8. DATE OF DEATH: *1956*

9. PLACE OF DEATH: *Home*

10. SIGNATURE OF PHYSICIAN: *[Signature]*

11. SIGNATURE OF REGISTRAR: *[Signature]*

12. SIGNATURE OF WITNESS: *[Signature]*

13. SIGNATURE OF DECEASED: *[Signature]*

14. SIGNATURE OF NEXT OF KIN: *[Signature]*

15. SIGNATURE OF BURIAL OFFICIAL: *[Signature]*

16. SIGNATURE OF FUNERAL HOME: *[Signature]*

17. SIGNATURE OF CHURCH OFFICIAL: *[Signature]*

18. SIGNATURE OF OTHER: *[Signature]*

19. SIGNATURE OF OTHER: *[Signature]*

20. SIGNATURE OF OTHER: *[Signature]*

21. SIGNATURE OF OTHER: *[Signature]*

22. SIGNATURE OF OTHER: *[Signature]*

23. SIGNATURE OF OTHER: *[Signature]*

24. SIGNATURE OF OTHER: *[Signature]*

25. SIGNATURE OF OTHER: *[Signature]*

26. SIGNATURE OF OTHER: *[Signature]*

27. SIGNATURE OF OTHER: *[Signature]*

28. SIGNATURE OF OTHER: *[Signature]*

29. SIGNATURE OF OTHER: *[Signature]*

30. SIGNATURE OF OTHER: *[Signature]*

31. SIGNATURE OF OTHER: *[Signature]*

32. SIGNATURE OF OTHER: *[Signature]*

33. SIGNATURE OF OTHER: *[Signature]*

34. SIGNATURE OF OTHER: *[Signature]*

35. SIGNATURE OF OTHER: *[Signature]*

36. SIGNATURE OF OTHER: *[Signature]*

37. SIGNATURE OF OTHER: *[Signature]*

38. SIGNATURE OF OTHER: *[Signature]*

39. SIGNATURE OF OTHER: *[Signature]*

40. SIGNATURE OF OTHER: *[Signature]*

41. SIGNATURE OF OTHER: *[Signature]*

42. SIGNATURE OF OTHER: *[Signature]*

43. SIGNATURE OF OTHER: *[Signature]*

44. SIGNATURE OF OTHER: *[Signature]*

45. SIGNATURE OF OTHER: *[Signature]*

46. SIGNATURE OF OTHER: *[Signature]*

47. SIGNATURE OF OTHER: *[Signature]*

48. SIGNATURE OF OTHER: *[Signature]*

49. SIGNATURE OF OTHER: *[Signature]*

50. SIGNATURE OF OTHER: *[Signature]*

51. SIGNATURE OF OTHER: *[Signature]*

52. SIGNATURE OF OTHER: *[Signature]*

53. SIGNATURE OF OTHER: *[Signature]*

54. SIGNATURE OF OTHER: *[Signature]*

55. SIGNATURE OF OTHER: *[Signature]*

56. SIGNATURE OF OTHER: *[Signature]*

57. SIGNATURE OF OTHER: *[Signature]*

58. SIGNATURE OF OTHER: *[Signature]*

59. SIGNATURE OF OTHER: *[Signature]*

60. SIGNATURE OF OTHER: *[Signature]*

61. SIGNATURE OF OTHER: *[Signature]*

62. SIGNATURE OF OTHER: *[Signature]*

63. SIGNATURE OF OTHER: *[Signature]*

64. SIGNATURE OF OTHER: *[Signature]*

65. SIGNATURE OF OTHER: *[Signature]*

66. SIGNATURE OF OTHER: *[Signature]*

67. SIGNATURE OF OTHER: *[Signature]*

68. SIGNATURE OF OTHER: *[Signature]*

69. SIGNATURE OF OTHER: *[Signature]*

70. SIGNATURE OF OTHER: *[Signature]*

71. SIGNATURE OF OTHER: *[Signature]*

72. SIGNATURE OF OTHER: *[Signature]*

73. SIGNATURE OF OTHER: *[Signature]*

74. SIGNATURE OF OTHER: *[Signature]*

75. SIGNATURE OF OTHER: *[Signature]*

76. SIGNATURE OF OTHER: *[Signature]*

77. SIGNATURE OF OTHER: *[Signature]*

78. SIGNATURE OF OTHER: *[Signature]*

79. SIGNATURE OF OTHER: *[Signature]*

80. SIGNATURE OF OTHER: *[Signature]*

81. SIGNATURE OF OTHER: *[Signature]*

82. SIGNATURE OF OTHER: *[Signature]*

83. SIGNATURE OF OTHER: *[Signature]*

84. SIGNATURE OF OTHER: *[Signature]*

85. SIGNATURE OF OTHER: *[Signature]*

86. SIGNATURE OF OTHER: *[Signature]*

87. SIGNATURE OF OTHER: *[Signature]*

88. SIGNATURE OF OTHER: *[Signature]*

89. SIGNATURE OF OTHER: *[Signature]*

90. SIGNATURE OF OTHER: *[Signature]*

91. SIGNATURE OF OTHER: *[Signature]*

92. SIGNATURE OF OTHER: *[Signature]*

93. SIGNATURE OF OTHER: *[Signature]*

94. SIGNATURE OF OTHER: *[Signature]*

95. SIGNATURE OF OTHER: *[Signature]*

96. SIGNATURE OF OTHER: *[Signature]*

97. SIGNATURE OF OTHER: *[Signature]*

98. SIGNATURE OF OTHER: *[Signature]*

99. SIGNATURE OF OTHER: *[Signature]*

100. SIGNATURE OF OTHER: *[Signature]*

RECEIVED

1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8033 CERTIFICATE OF DEATH

08003

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2315 Old Frederick Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRIETT Middle C Last HAZZARD		4. DATE OF DEATH Month August Day 1 Year 1956		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-26-1874		9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Alice H. Dallard, Catonsville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Generalized Arteriosclerosis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Aug 56 to 1 Aug 56 , that I last saw the deceased alive on 1 Aug 56 , and that death occurred at 8:10 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 1707 Edmondson Ave. Catonsville 28 Md DATE SIGNED 1 Aug 56			
ACTUAL SIGNATURE W. E. McGroth M.D.				DATE SIGNED 1 Aug 56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8-2-56		22c. NAME OF CEMETERY OR CREMATORY Louisa Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higinbotham, Ellicott City, Md.				24. RECD BY REGISTRAR Aug 2 1956 24b. REGISTRAR'S SIGNATURE T. E. Harry			

CERTIFICATE OF DEATH

8023

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1955

Name of Deceased William H. Johnson		Sex Male		Date of Birth 12-24-1874	
Place of Birth London, England		Race White		Religion Episcopal	
Usual Residence 1312 Old Frederick Road, Baltimore, Md.		Cause of Death Heart Disease		Manner of Death Natural	
Date of Death August 1, 1955		Time of Death 10:30 AM		Place of Death Home	
Physician Dr. Alice H. Johnson, Baltimore, Md.		Hospital None		Burial Place None	
Signature of Physician [Signature]		Signature of Registrar [Signature]		Signature of Coroner [Signature]	
City Baltimore		County Harford		State Md.	
Country U.S.A.		Age 80		Sex Male	
Race White		Religion Episcopal		Marital Status Married	
Education High School		Occupation None		Previous Illnesses Heart Disease	
Date of Death August 1, 1955		Time of Death 10:30 AM		Place of Death Home	
Physician Dr. Alice H. Johnson, Baltimore, Md.		Hospital None		Burial Place None	
Signature of Physician [Signature]		Signature of Registrar [Signature]		Signature of Coroner [Signature]	
City Baltimore		County Harford		State Md.	
Country U.S.A.		Age 80		Sex Male	
Race White		Religion Episcopal		Marital Status Married	
Education High School		Occupation None		Previous Illnesses Heart Disease	

BUREAU V. S.

AUG 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8034

CERTIFICATE OF DEATH

0800444

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 29				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 29			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 206 Westshire Rd.				d. STREET ADDRESS 206 Westshire Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CATHERINE Middle GRACE Last HENZLER				4. DATE OF DEATH Month Aug. Day 20, Year 19 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1898		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? -	
13. FATHER'S NAME John Henzler				14. MOTHER'S MAIDEN NAME Harriet Elizabeth Dorsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Harry Henzler - 734 Edgewood St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Thrombosis DUE TO Essential Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) -						INTERVAL BETWEEN ONSET AND DEATH 48 hours 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 18 , 19 56 , to Aug 20 , 19 56 , that I last saw the deceased alive on Aug 20 , 19 56 , and that death occurred at 11:20 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE L. A. Lally		M.D.		ADDRESS (Street, city or town, state) 3517 Edmondson Avenue		DATE SIGNED	
PHYSICIAN'S NAME (Type) L. A. Lally							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/22/56		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Schenker & Sons, Balto, Md				24a. REC'D BY REGISTRAR DATE Aug 23 1956		24b. REGISTRAR'S SIGNATURE Dr. L. M. Zieffler	

BUREAU V. S.

AUG 24 1956

RECEIVED

8035

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY in 1b <u>5 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown.</u>	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Preston</u> Last <u>Higgs</u>		4. DATE OF DEATH Month <u>8</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1863</u>
		9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>Henry Eugene Higgs</u>		14. MOTHER'S MAIDEN NAME <u>Mary Indiana Hayden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
		17. INFORMANT <u>MRS Leland Higgs</u> Address <u>Randallstown, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY EDEMA; c KIDNEY FAILURE</u> DUE TO (c) <u>HYPERTENSIVE C.V. DISEASE - SEVERE.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>10 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>APRIL 6, 1956</u> to <u>AUG - 10</u> , 1956, that I last saw the deceased alive on <u>AUG 10</u> , 1956, and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas E. Wheeler</u>		ADDRESS (Street, city or town, state) <u>3601 CLIFMAR RD - BALTO 7 - MD</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>		DATE SIGNED <u>8/10/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-13-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Chaptico, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Waldorf, Md.</u>	
		24b. REGISTRAR'S SIGNATURE <u>AUG 15 1956 Dorothy Russell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 15 1956

BUREAU V. S.

CERTIFICATE OF DEATH

TO DEPUTY:

execute the

forwarded

TO FUNERAL DIRECTOR:

or removal.

VS. A15ME(5)
5M 9/55

DICAL EXAMINER: This certificate should be executed within 24 hours after death. If any del-
cate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral c.
the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

necessary, please exe-
Page 4 should be
to burial, cremation



5.
00



9930

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL or the nearest town) DUNDALK 22		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Balt.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 68 PORTSHIP Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 53	
3. NAME OF DECEASED (Type or print) First HA RRIETT Middle M. Last HILL		4. DATE OF DEATH Month August Day 20 Year 1956		9. AGE (In years last birthday) 45 yrs.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/11/1911	IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min. 15	IF UNDER 24 HRS. Months 15 Days 15 Hours 15 Min. 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S. CAROLINA	
13. FATHER'S NAME ERNEST HILL		14. MOTHER'S MAIDEN NAME NELLIE EZELL		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 248-20-1501		17. INFORMANT CLARENCE H. HILL - 5 HAWK Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Functional heart disease -- auricular tachycardia DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
---	--	----------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
---	--	--

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE **R. S. Fisher** M.D. CHIEF MEDICAL EXAMINER ☒ DATE SIGNED **8/21/56**
EXAMINER'S NAME (Type) **Russell S. Fisher, M.D.** ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/24/56	22c. NAME OF CEMETERY OR CREMATORY GREENLAND	22d. LOCATION (City, town, or county) (State) GREENVILLE, S. C.
23. FUNERAL DIRECTOR'S SIGNATURE W. B. Fisher, Dundalk, Md.		24a. REC'D BY REGISTRAR 23 1956	24b. REGISTRAR'S SIGNATURE Wm. P. Kelly

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

AUG 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8936 CERTIFICATE OF DEATH

08006

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last HOBBS				4. DATE OF DEATH Month August Day 11 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/18/98	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months 11 Days 11 Hours 19 Min.	IF UNDER 24 HRS. Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician				10b. KIND OF BUSINESS OR INDUSTRY Construction Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Alexander H. Hobbs			
14. MOTHER'S MAIDEN NAME Mary Bowling				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II			
16. SOCIAL SECURITY NO. 212-05-7726				17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOSARCOMA 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. n. Month 19 Day 19 Year 1956 p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from August 8 , 19 56 , to August 11 , 19 56 , and that death occurred at 10:00 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur G. Edwards				ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland			
DATE SIGNED 8/12/56				PHYSICIAN'S NAME (Type) ARTHUR G. EDWARDS, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/15/1956		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Rick Funeral Home				ADDRESS 5306 Harford Road		24a. REC'D BY REGISTRAR 14 1956	
24b. REGISTRAR'S SIGNATURE Dawson L. Ferkley				DATE 14 1956			

RECEIVED

15 AUG 1956

BUREAU V.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08007

8037

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>MARYLAND</u>		COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		LENGTH OF STAY (in this place) <u>89 YRS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1407 Midvale Ave.</u>				STREET ADDRESS (If rural give location) <u>1407 Midvale Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>AUGUST FREDERICK HOERL</u>				4. DATE OF DEATH <u>AUG. 9, 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>FEB. 10, 1867</u>	
9. AGE last birthday <u>89 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER Bldg. + REPAIRS</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE HOERL</u>				14. MOTHER'S MAIDEN NAME <u>CHRISTINE P.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S ADDRESS <u>Mrs. Chester Sadler, 1407 Midvale Ave, Catonsville 28, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
181X IMMEDIATE CAUSE (A) <u>General Carcinomatosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 Months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of Bladder</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>216</u>, 19 <u>56</u>, to <u>89</u>, 19 <u>56</u>, that I last saw the deceased alive on <u>7/13/56</u>, 19 <u>56</u>, and that death occurred at <u>6:35 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>Edwin W. Johnson</u>		M.D. <u>3432 Reservoir Ave</u>		DATE SIGNED <u>8/9/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>8/11/56</u>		NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEM.</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u>	
24. REC'D BY REGISTRAR <u>U.E. Harry</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons</u>		ADDRESS <u>Catonsville 28, Md.</u>	
DATE <u>8/10/56</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

3087

1. Name of deceased (Print or type)

JOHN
JOHN
JOHN

1950

1950

1950

1950

1950

1950

BUREAU V. 1

AUG 13 1956

RECEIVED

EXHIBIT 1234

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 8,9,11 FilmG202 9-4-56 et
8038
CERTIFICATE OF DEATH

08008

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>574 Sue Grover Rd. Essex</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>IVY HALL</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Coroline A</u> First Middle Last				4. DATE OF DEATH <u>August 26</u> Month Day Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 15 1898</u> 9. AGE (In years last birthday) <u>56</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Henninger</u>				14. MOTHER'S MAIDEN NAME <u>Coroline H. Kahler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>1645</u>		17. INFORMANT <u>Harry L. Hoey</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Pancreas</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>56</u> , to <u>Aug 26</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Aug 26</u> , 19 <u>56</u> , and that death occurred at <u>3:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G.M. Baumgardner M.D.</u>				ADDRESS (Street, city or town, state) <u>Balto 6 Md</u>		DATE SIGNED <u>8/26/56</u>	
PHYSICIAN'S NAME (Type) <u>G.M. BAUMGARDNER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8-29-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wood Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Szymanski</u> ADDRESS <u>1407 Eastern Ave</u>				24a. REC'D BY REGISTRAR DATE <u>8/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 8939 CERTIFICATE OF DEATH

08009

Reg. Dist. No.

45

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>413 Woodbine Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Henry Holt</u>				4. DATE OF DEATH Month Day Year <u>Aug. 20th, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22, 1902</u>		9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Capt. Fire Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto Co. Fire Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Holt</u>				14. MOTHER'S MAIDEN NAME <u>Amelia ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. #1</u>		17. INFORMANT <u>Louise Holt (Wife)</u>		Address <u>Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 20, 1956</u> to <u>Aug 20, 1956</u> , that I last saw the deceased alive on <u>Aug 20, 1956</u> , and that death occurred at <u>1035 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph Miceli</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>423 Eastern Ave 8/21/56</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI M.D.</u>				<u>Essex 21, 429</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 24, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Eastern Blvd., Balto Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly</u>				ADDRESS <u>418 Eastern Blvd. Essex, Md.</u>		24a. REC'D BY REGISTRAR <u>Edith Hurley</u>	
				24b. REGISTRAR'S SIGNATURE			

RECEIVED

AUG 22 1956

BUREAU V. S.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BIRTH AND DEATH RECORDS

CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF BIRTH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8040

CERTIFICATE OF DEATH

08010

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 44 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1622 North Gilmore Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle HUNTLEY, JR. Last HUNTLEY, JR.				4. DATE OF DEATH Month August Day 5 Year 19 56			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1, 1906	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardening and Custodian Private Home				10b. KIND OF BUSINESS OR INDUSTRY Wadesboro, N. Carolina		11. BIRTHPLACE (State or foreign country) U. S. A.	
13. FATHER'S NAME Henry Huntley				14. MOTHER'S MAIDEN NAME Nettia Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF ESOPHAGUS 150 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 22 , 1956, to August 5 , 1956, and that death occurred at 1:25 P.M. from the causes and on the date stated above. Arthur G. Edwards ADDRESS (Street, city or town, state) M.D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 8/6/56							
ACTUAL SIGNATURE ARTHUR G. EDWARDS, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8/10/56		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Fort Myer, Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Low Mortuary 802-04 Madison Ave				24a. REC'D BY REGISTRAR Aug 10 - 56 Dawson L. Farber		24b. REGISTRAR'S SIGNATURE	

VS A15 (4)
15M 9/55

Shipped to: Frazier's Funeral Home, Inc. 389 Rhode Island (Baltimore, Md.)
Washington, D.C.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

DECEASED NAME LAST, FIRST, MIDDLE JAMES EARL RAY		SEX MALE		DATE OF BIRTH JANUARY 5, 1928		PLACE OF BIRTH MOBILE, ALABAMA	
OCCUPATION MEMBER OF CONGRESS		MARITAL STATUS SINGLE		EDUCATION HIGH SCHOOL		RELIGION METHODIST	
DECEASED'S ADDRESS 1000 ...		DECEASED'S PHONE ...		DECEASED'S CITY ...		DECEASED'S STATE ...	
DECEASED'S COUNTRY ...		DECEASED'S RACE ...		DECEASED'S COLOR ...		DECEASED'S COMPLEXION ...	
DECEASED'S HEIGHT ...		DECEASED'S WEIGHT ...		DECEASED'S HAIR ...		DECEASED'S EYES ...	
DECEASED'S BUILD ...		DECEASED'S TENDENCY ...		DECEASED'S DISEASE ...		DECEASED'S CAUSE ...	
DECEASED'S DATE OF DEATH ...		DECEASED'S TIME OF DEATH ...		DECEASED'S PLACE OF DEATH ...		DECEASED'S CITY OF DEATH ...	
DECEASED'S STATE OF DEATH ...		DECEASED'S COUNTRY OF DEATH ...		DECEASED'S RACE OF DEATH ...		DECEASED'S COLOR OF DEATH ...	
DECEASED'S BUILD OF DEATH ...		DECEASED'S TENDENCY OF DEATH ...		DECEASED'S DISEASE OF DEATH ...		DECEASED'S CAUSE OF DEATH ...	
DECEASED'S HEIGHT OF DEATH ...		DECEASED'S WEIGHT OF DEATH ...		DECEASED'S HAIR OF DEATH ...		DECEASED'S EYES OF DEATH ...	
DECEASED'S BUILD OF DEATH ...		DECEASED'S TENDENCY OF DEATH ...		DECEASED'S DISEASE OF DEATH ...		DECEASED'S CAUSE OF DEATH ...	

BUREAU V. 3

AUG 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8041

CERTIFICATE OF DEATH

08011

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 16 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RAYMOND Middle L. Last IRISH				4. DATE OF DEATH Month August Day 18 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/12/83	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Delivery Man		10b. KIND OF BUSINESS OR INDUSTRY Coal Business	
11. BIRTHPLACE (State or foreign country) Colton, New York				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Herbert Irish				14. MOTHER'S MAIDEN NAME E. Lorena Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I		17. INFORMANT CLIN.REC.VET.ADM.HOSP.,FT. HOWARD, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MYOCARDIAL INFARCTION DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 2 , 19 56 , to Aug. 18 , 19 56 , and that death occurred at 9:50A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Cardad E. Gonzalez				ADDRESS (Street, city or town, state) VAH, Fort Howard, Md.			
PHYSICIAN'S NAME (Type) CARDAD E. GONZALEZ, M. D.				DATE SIGNED 8/18/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-21-56		22c. NAME OF CEMETERY OR CREMATORY Park Wood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Bright				24a. REC'D BY REGISTRAR Aug 23 1956			
ADDRESS 6009 Harford Rd. Balto, Md.				24b. REGISTRAR'S SIGNATURE Newson L. Farber			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
John Edward		August 18, 1956		Baltimore, Maryland	
AGE		SEX		RACE	
45		Male		White	
BIRTH DATE		BIRTH PLACE		MARRIAGE	
August 18, 1911		Baltimore, Maryland		Married	
OCCUPATION		EDUCATION		RELIGION	
Salesman		High School		Roman Catholic	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH	
None		Heart Disease		Natural	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	
[Signature]		[Signature]		August 23, 1956	

BUREAU V. 2

AUG 23 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

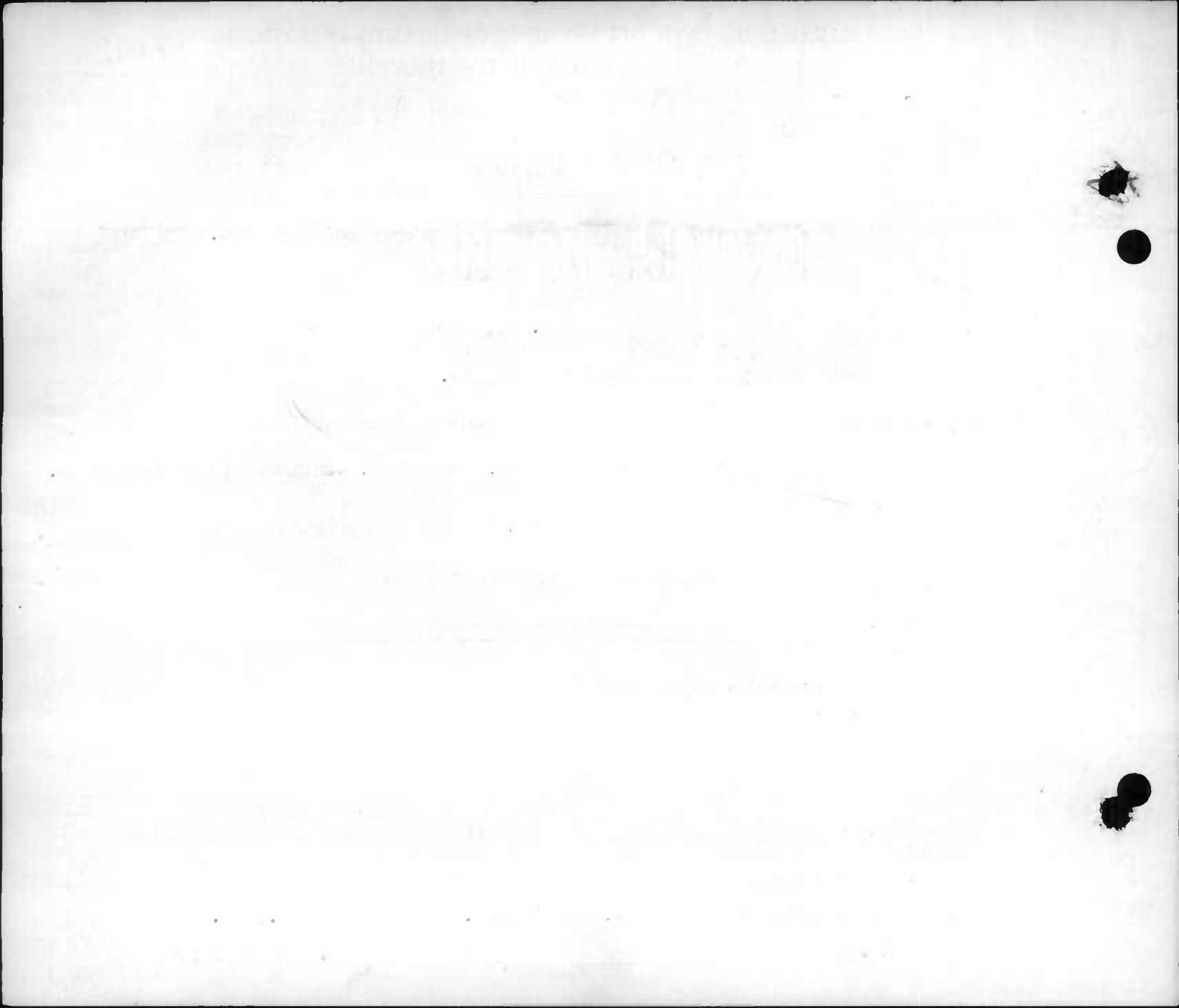
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8042

CERTIFICATE OF DEATH

Reg. Dist. No. 08012

1. PLACE OF DEATH: 2549 Lodge Forest Drive COUNTY Baltimore MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS Forest Lodge Home				2. USUAL RESIDENCE (HOME) OF DECEASED: 2529 Wentworth Road STATE Maryland COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore STREET ADDRESS (If rural, give location) 2529 Wentworth Rd.			
3. NAME OF DECEASED: (Type or Print)		(First) Aleathea		(Middle) Ann		(Last) Jenkins	
4. DATE OF DEATH:		8		8		19 56	
5. SEX: F		6. COLOR OR RACE: W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: Aug. 11, 1862	
9. AGE last birthday: 93 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self Employed Dress Maker				10b. KIND OF BUSINESS OR INDUSTRY: Md.		11. BIRTHPLACE (State or foreign country): Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME: Robert Jenkins				14. MOTHER'S MAIDEN NAME: Rachael Ruth Warfield			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY No.: none		17. INFORMANT & ADDRESS: Mr. Charles T. Jenkins-2529 Wentworth Rd.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.0 Immediate cause (a) Arteriosclerotic Heart Disease						3 yrs.	
Antecedent cause(s) (b) Generalized Arteriosclerosis						6 yrs.	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not while M. work <input type="checkbox"/> at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 18, 1956, to Aug. 8, 1956, that I last saw the deceased alive on Aug. 8, 1956, and that death occurred at 9:30 P.M., from the causes and on the date stated above.							
SIGNATURE James G. Means		(DEGREE OR TITLE) M.D.		ADDRESS 520 N. St. Balto 19 Md.		DATE SIGNED 8/10/56	
23. BURIAL, CREMATION REMOVAL (Specify): Burial		DATE THEREOF 8/11/56		NAME OF CEMETERY OR CREMATORY St. Mary's Cem.		LOCATION (City, town, or county) Balto., Md.	
DATE REC'D BY LOCAL REC. August 11, 1956		REGISTRAR'S SIGNATURE R.W.		24. FUNERAL DIRECTOR Thos. J. Tichenor & Sons - Balto. Md.		ADDRESS Balto. Md.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8043
CERTIFICATE OF DEATH

08013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO. CITY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. LENGTH OF STAY IN 1b 30	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS— 1508 E. FORT AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROBERT First B. Middle JOHNSTON Last		4. DATE OF DEATH Month 8 Day 5 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3.15.92
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME ANDREW B. JOHNSTON		14. MOTHER'S MAIDEN NAME MARY L. HOLMES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-07-8189	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) FAR ADVANCED PULMONARY TUBERCULOSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH FEB. 1956	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3.28 , 19 56 , to 8.5 , 19 56 , that I last saw the deceased alive on 8.5 , 19 56 , and that death occurred at 10:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William Newcomer M.D.			
PHYSICIAN'S NAME (Type) William Newcomer M.D.		Mt. Wilson Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/56	
22c. NAME OF CEMETERY OR CREMATORY New Catholic Cem. Balt. Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles F. Hill ADDRESS 1501 E. Fort Ave.		24a. REC'D BY REGISTRAR Aug. 9, 1956	
		24b. REGISTRAR'S SIGNATURE Dorothy Maxwell	

CERTIFICATE OF DEATH

3003

1. NAME OF DECEASED JAMES H. BASTARD		2. SEX Male	
3. AGE 30		4. DATE OF BIRTH 1928	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION None	
7. MARITAL STATUS Single		8. CAUSE OF DEATH Heart Disease	
9. DATE OF DEATH 1956		10. PLACE OF DEATH Home	
11. SIGNATURE OF DECEASED (None)		12. SIGNATURE OF WITNESSES (None)	
13. SIGNATURE OF PHYSICIAN (None)		14. SIGNATURE OF CORONER (None)	
15. SIGNATURE OF REGISTRAR (None)		16. SIGNATURE OF CLERK (None)	
17. SIGNATURE OF JURY (None)		18. SIGNATURE OF JUDGE (None)	
19. SIGNATURE OF DISTRICT ATTORNEY (None)		20. SIGNATURE OF COUNTY CLERK (None)	
21. SIGNATURE OF STATE CLERK (None)		22. SIGNATURE OF SECRETARY (None)	
23. SIGNATURE OF ASSISTANT SECRETARY (None)		24. SIGNATURE OF CHIEF CLERK (None)	
25. SIGNATURE OF DEPUTY CLERK (None)		26. SIGNATURE OF RECORDS CLERK (None)	
27. SIGNATURE OF FILE CLERK (None)		28. SIGNATURE OF INDEX CLERK (None)	
29. SIGNATURE OF RESEARCH CLERK (None)		30. SIGNATURE OF QUALITY CONTROL CLERK (None)	
31. SIGNATURE OF COMPLAINT CLERK (None)		32. SIGNATURE OF INVESTIGATION CLERK (None)	
33. SIGNATURE OF ADJUDICATION CLERK (None)		34. SIGNATURE OF APPEALS CLERK (None)	
35. SIGNATURE OF RECORDS CLERK (None)		36. SIGNATURE OF FILE CLERK (None)	
37. SIGNATURE OF INDEX CLERK (None)		38. SIGNATURE OF RESEARCH CLERK (None)	
39. SIGNATURE OF QUALITY CONTROL CLERK (None)		40. SIGNATURE OF COMPLAINT CLERK (None)	
41. SIGNATURE OF INVESTIGATION CLERK (None)		42. SIGNATURE OF ADJUDICATION CLERK (None)	
43. SIGNATURE OF APPEALS CLERK (None)		44. SIGNATURE OF RECORDS CLERK (None)	
45. SIGNATURE OF FILE CLERK (None)		46. SIGNATURE OF INDEX CLERK (None)	
47. SIGNATURE OF RESEARCH CLERK (None)		48. SIGNATURE OF QUALITY CONTROL CLERK (None)	
49. SIGNATURE OF COMPLAINT CLERK (None)		50. SIGNATURE OF INVESTIGATION CLERK (None)	
51. SIGNATURE OF ADJUDICATION CLERK (None)		52. SIGNATURE OF APPEALS CLERK (None)	
53. SIGNATURE OF RECORDS CLERK (None)		54. SIGNATURE OF FILE CLERK (None)	
55. SIGNATURE OF INDEX CLERK (None)		56. SIGNATURE OF RESEARCH CLERK (None)	
57. SIGNATURE OF QUALITY CONTROL CLERK (None)		58. SIGNATURE OF COMPLAINT CLERK (None)	
59. SIGNATURE OF INVESTIGATION CLERK (None)		60. SIGNATURE OF ADJUDICATION CLERK (None)	
61. SIGNATURE OF APPEALS CLERK (None)		62. SIGNATURE OF RECORDS CLERK (None)	
63. SIGNATURE OF FILE CLERK (None)		64. SIGNATURE OF INDEX CLERK (None)	
65. SIGNATURE OF RESEARCH CLERK (None)		66. SIGNATURE OF QUALITY CONTROL CLERK (None)	
67. SIGNATURE OF COMPLAINT CLERK (None)		68. SIGNATURE OF INVESTIGATION CLERK (None)	
69. SIGNATURE OF ADJUDICATION CLERK (None)		70. SIGNATURE OF APPEALS CLERK (None)	
71. SIGNATURE OF RECORDS CLERK (None)		72. SIGNATURE OF FILE CLERK (None)	
73. SIGNATURE OF INDEX CLERK (None)		74. SIGNATURE OF RESEARCH CLERK (None)	
75. SIGNATURE OF QUALITY CONTROL CLERK (None)		76. SIGNATURE OF COMPLAINT CLERK (None)	
77. SIGNATURE OF INVESTIGATION CLERK (None)		78. SIGNATURE OF ADJUDICATION CLERK (None)	
79. SIGNATURE OF APPEALS CLERK (None)		80. SIGNATURE OF RECORDS CLERK (None)	
81. SIGNATURE OF FILE CLERK (None)		82. SIGNATURE OF INDEX CLERK (None)	
83. SIGNATURE OF RESEARCH CLERK (None)		84. SIGNATURE OF QUALITY CONTROL CLERK (None)	
85. SIGNATURE OF COMPLAINT CLERK (None)		86. SIGNATURE OF INVESTIGATION CLERK (None)	
87. SIGNATURE OF ADJUDICATION CLERK (None)		88. SIGNATURE OF APPEALS CLERK (None)	
89. SIGNATURE OF RECORDS CLERK (None)		90. SIGNATURE OF FILE CLERK (None)	
91. SIGNATURE OF INDEX CLERK (None)		92. SIGNATURE OF RESEARCH CLERK (None)	
93. SIGNATURE OF QUALITY CONTROL CLERK (None)		94. SIGNATURE OF COMPLAINT CLERK (None)	
95. SIGNATURE OF INVESTIGATION CLERK (None)		96. SIGNATURE OF ADJUDICATION CLERK (None)	
97. SIGNATURE OF APPEALS CLERK (None)		98. SIGNATURE OF RECORDS CLERK (None)	
99. SIGNATURE OF FILE CLERK (None)		100. SIGNATURE OF INDEX CLERK (None)	

BUREAU V. 1

JUG 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08014

Reg. Dist. No.

7946

1. PLACE OF DEATH a. COUNTY <u>Dundalk, Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3402 Cornwall Road</u>				d. STREET ADDRESS <u>3402 Cornwall Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Albert J. Jordan</u>				4. DATE OF DEATH Month Day Year <u>August 1 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 18, 1904</u>		9. AGE (In years last birthday) <u>52</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Timonium</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>			
13. FATHER'S NAME <u>Thomas Jordan</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Mauler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs Lillian Bernice 3402 Cornwall Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bullet Wound thru Right</u> <u>976x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Temporal Region</u> DUE TO (c) </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>1</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot Self Thru Rt. Temporal Region</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>8-1-56</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>One on Street</u>			
20f. (City or town) <u>Dundalk</u>		20g. (County) <u>Baltimore</u>		20h. (State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/3/56</u>			
EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 6, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>			
22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		22e. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lilly & Zeiler Inc., 403 S. Wolfe St.</u>				24a. REC'D BY REGISTRAR <u>DATE AUG 3 1956</u>			
24b. REGISTRAR'S SIGNATURE <u>M. P. Kelly</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAKING STATE DEPARTMENT OF HEALTH - BANGKOK 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		DATE OF DEATH		PLACE OF DEATH	
JAMES DOUGLAS		35		Male		1956		Bangkok	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH	
Teacher		High School		Married		Buddhist		Heart Disease	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF ENTRY INTO COUNTRY		DATE OF LAST EXAMINATION		DATE OF LAST VISIT	
1921		USA		1950		1956		1956	
HEIGHT		WEIGHT		TEMPERATURE		PULSE		BLOOD PRESSURE	
5' 10"		170 lbs		98.6		72		120/80	
COLOR OF SKIN		COLOR OF EYES		COLOR OF HAIR		COLOR OF NAILS		COLOR OF TONGUE	
Fair		Blue		Brown		Pink		Pink	
COLOR OF URINE		COLOR OF STOOL		COLOR OF SPUTUM		COLOR OF SALIVA		COLOR OF SWEAT	
Yellow		Brown		White		Clear		Clear	
COLOR OF URINE (2nd)		COLOR OF STOOL (2nd)		COLOR OF SPUTUM (2nd)		COLOR OF SALIVA (2nd)		COLOR OF SWEAT (2nd)	
Yellow		Brown		White		Clear		Clear	
COLOR OF URINE (3rd)		COLOR OF STOOL (3rd)		COLOR OF SPUTUM (3rd)		COLOR OF SALIVA (3rd)		COLOR OF SWEAT (3rd)	
Yellow		Brown		White		Clear		Clear	
COLOR OF URINE (4th)		COLOR OF STOOL (4th)		COLOR OF SPUTUM (4th)		COLOR OF SALIVA (4th)		COLOR OF SWEAT (4th)	
Yellow		Brown		White		Clear		Clear	
COLOR OF URINE (5th)		COLOR OF STOOL (5th)		COLOR OF SPUTUM (5th)		COLOR OF SALIVA (5th)		COLOR OF SWEAT (5th)	
Yellow		Brown		White		Clear		Clear	
COLOR OF URINE (6th)		COLOR OF STOOL (6th)		COLOR OF SPUTUM (6th)		COLOR OF SALIVA (6th)		COLOR OF SWEAT (6th)	
Yellow		Brown		White		Clear		Clear	
COLOR OF URINE (7th)		COLOR OF STOOL (7th)		COLOR OF SPUTUM (7th)		COLOR OF SALIVA (7th)		COLOR OF SWEAT (7th)	
Yellow		Brown		White		Clear		Clear	
COLOR OF URINE (8th)		COLOR OF STOOL (8th)		COLOR OF SPUTUM (8th)		COLOR OF SALIVA (8th)		COLOR OF SWEAT (8th)	
Yellow		Brown		White		Clear		Clear	
COLOR OF URINE (9th)		COLOR OF STOOL (9th)		COLOR OF SPUTUM (9th)		COLOR OF SALIVA (9th)		COLOR OF SWEAT (9th)	
Yellow		Brown		White		Clear		Clear	
COLOR OF URINE (10th)		COLOR OF STOOL (10th)		COLOR OF SPUTUM (10th)		COLOR OF SALIVA (10th)		COLOR OF SWEAT (10th)	
Yellow		Brown		White		Clear		Clear	

BUREAU V. 8

JUG 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08015

8944

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Villa Julie</u>		d. STREET ADDRESS <u>Villa Julie Valley Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Sister Rita Agnes</u> First Middle Last		4. DATE OF DEATH <u>Aug. 26</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12, 1888</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Anthony Keuping</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Muesman</u>	
15. WAS DECEASED EVER IN U. S. ARMY, NAVY, OR AIR FORCE? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT <u>Sister Marie Dolores</u>		Address <u>Villa Julie</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis with</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>softening of the brain.</u> DUE TO (c) <u>myocarditis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> 19____, to <u>Aug 26</u> , 1956, that I last saw the deceased alive on <u>Aug 25</u> , 1956, and that death occurred at <u>1:35 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold H Burns</u>		ADDRESS (Street, city or town, state) <u>115 E. Cager St</u> DATE SIGNED <u>Aug 27, 1956</u>	
PHYSICIAN'S NAME (Type) <u>Harold H. Burns, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-28-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Convent Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Ilchester Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Foley Funeral Home - Catonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8/28/56</u>	24b. REGISTRAR'S SIGNATURE <u>Dorothy Jewell</u>

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. TIME OF DEATH</p>		<p>10. PLACE OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>	
<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF CORONER</p>	
<p>15. SIGNATURE OF JUDGE</p>		<p>16. SIGNATURE OF CLERK</p>	

BUREAU V. 31

1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8045
CERTIFICATE OF DEATH

08016

Reg. Dist. No. **44**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 38 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLEMENT Middle W. Last KIMMONS				4. DATE OF DEATH Month August Day 26 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/30/88	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Fiber Company		11. BIRTHPLACE (State or foreign country) Phoenixville, N.C.	
12. CITIZEN OF WHAT COUNTRY U.S.A.							
13. FATHER'S NAME Victor Kimmons				14. MOTHER'S MAIDEN NAME Alice Overcash			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> WW-I				16. SOCIAL SECURITY NO. 216 10 8053		17. INFORMANT Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) THROMBOSIS PULMONARY ARTERIES BILATERAL 450.0 DUE TO GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PREVIOUS CEREBRAL VESSEL THROMBOSIS - 6 MONTHS						INTERVAL BETWEEN ONSET AND DEATH 5 HOURS UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 19 19 56 , to August 26 19 56 , and that death occurred at 8:55A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur G. Edwards M.D.				ADDRESS (Street, city or town, state) Fort Howard, Md. DATE SIGNED 8-26-56			
PHYSICIAN'S NAME (Type) Arthur G. EDWARDS, M.D.				ADDRESS Fort Howard, Maryland 8-26-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-29-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Blight, Inc ADDRESS 6009 Harford Rd. Balto Md				24a. REC'D BY REGISTRAR 8/27/56		24b. REGISTRAR'S SIGNATURE Dr. Dawson D. Foster	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956 29 AUG

BUREAU V. 51

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08017

8046

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY OR TOWN Woodbrook		LENGTH OF STAY (in this place) 7 Mos.		CITY OR TOWN Woodbrook			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6325 N. Charles St.				STREET ADDRESS (If rural give location) 6325 N. Charles St.			
3. NAME OF DECEASED (Type or Print) Emily N. King				4. DATE OF DEATH (Month) Aug (Day) 15 (Year) 1956			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH Sept 4-1878		9. AGE last birthday 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. Flaharty				14. MOTHER'S MAIDEN NAME Emma Poole			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Clarence King 6325 N. Charles St.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
260X IMMEDIATE CAUSE (A) Chronic Myocarditis						INTERVAL BETWEEN ONSET AND DEATH Unknown	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis						Unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Diabetes Mellitus						26+ yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Epigastric Tumor Mass Undiagnosed						3 mos	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 27, 1932 , to Aug 15, 1956 , that I last saw the deceased alive on Aug 14, 1956 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city, town, state) M.D. 3403 Garrison Blvd Baltimore, Md.		DATE SIGNED 8/16/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug-18-1956		NAME OF CEMETERY OR CREMATORY Druid Ridge		LOCATION (City, town, or county) Pikesville, Md.	
24. REC'D BY REGISTRAR DATE AUG 16 1956		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS 2224 N. Charles St.	

BUREAU OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

Form 100-100

DEPARTMENT OF HEALTH - BALTIMORE

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

Registration

BUREAU V. 1

AUG 17 1956

RECEIVED

2200 E. Charles St.

BALTIMORE

This certificate is to be filled out by the physician or other person authorized by the Department of Health, Baltimore, Maryland, to issue such certificates. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, and a copy of it is to be sent to the office of the State Registrar of the Department of Health, Baltimore, Maryland.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8049

CERTIFICATE OF DEATH

0801820

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home		d. STREET ADDRESS 522 N. Payson Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAY Middle KOONTZ Last KOONTZ		4. DATE OF DEATH Month 8 Day 2 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/17/1871
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Jewell		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Frances Koontz - 4021 Colborne Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 55 , to Aug 2 , 19 56 , that I last saw the deceased alive on July 31 , 19 56 , and that death occurred at 7:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4605 EDMONDSON AVE BALTIMORE 29, Md DATE SIGNED 8/4/56			
ACTUAL SIGNATURE Cliff Ratliff Jr. M.D.		PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR. BALTIMORE 29, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/4/56	22c. NAME OF CEMETERY OR CREMATORY Lodon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker ADDRESS Home - North & Pa Aves Baltimore - Md		24a. REC'D BY REGISTRAR 6 DATE 1956	
24b. REGISTRAR'S SIGNATURE F. E. Harvey			

BUREAU V. S.

AUG 7 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08019

8053

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore 7	
HOSPITAL OR INSTITUTION OR STREET ADDRESS House in the Pines 16 Fusting Ave.		STREET ADDRESS (If rural, give location) 6820 Windsor Mill Rd.	
3. NAME OF DECEASED (First) MARY (Middle) FRANCES (Last) Kratt		4. DATE OF DEATH (Month) 8 (Day) 14 (Year) 1956	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH June 20, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 84 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Entwisle		14. MOTHER'S MAIDEN NAME Augusta -	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. No	
17. INFORMANT AND ADDRESS Mrs. Alice D. Joiner - 6820 Windsor Mill Rd.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

4438 Immediate cause	(a) Pneumonia Rt. upper & middle lobes	Interval
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Ch. Hypertension Cardio-Vascular Disease	20 yr. (?)
(c)		

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.**Cerebral Hemorrhage****2 mo**

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7-4**, 19**56**, to **8-14**, 19**56**, that I last saw the deceased alive on **8-13**, 19**56**, and that death occurred at **5:30 a.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 8/16/56	NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	LOCATION (City, town, or county) Woodlawn, Md.	(State)
--	--------------------------------	---	--	---------

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

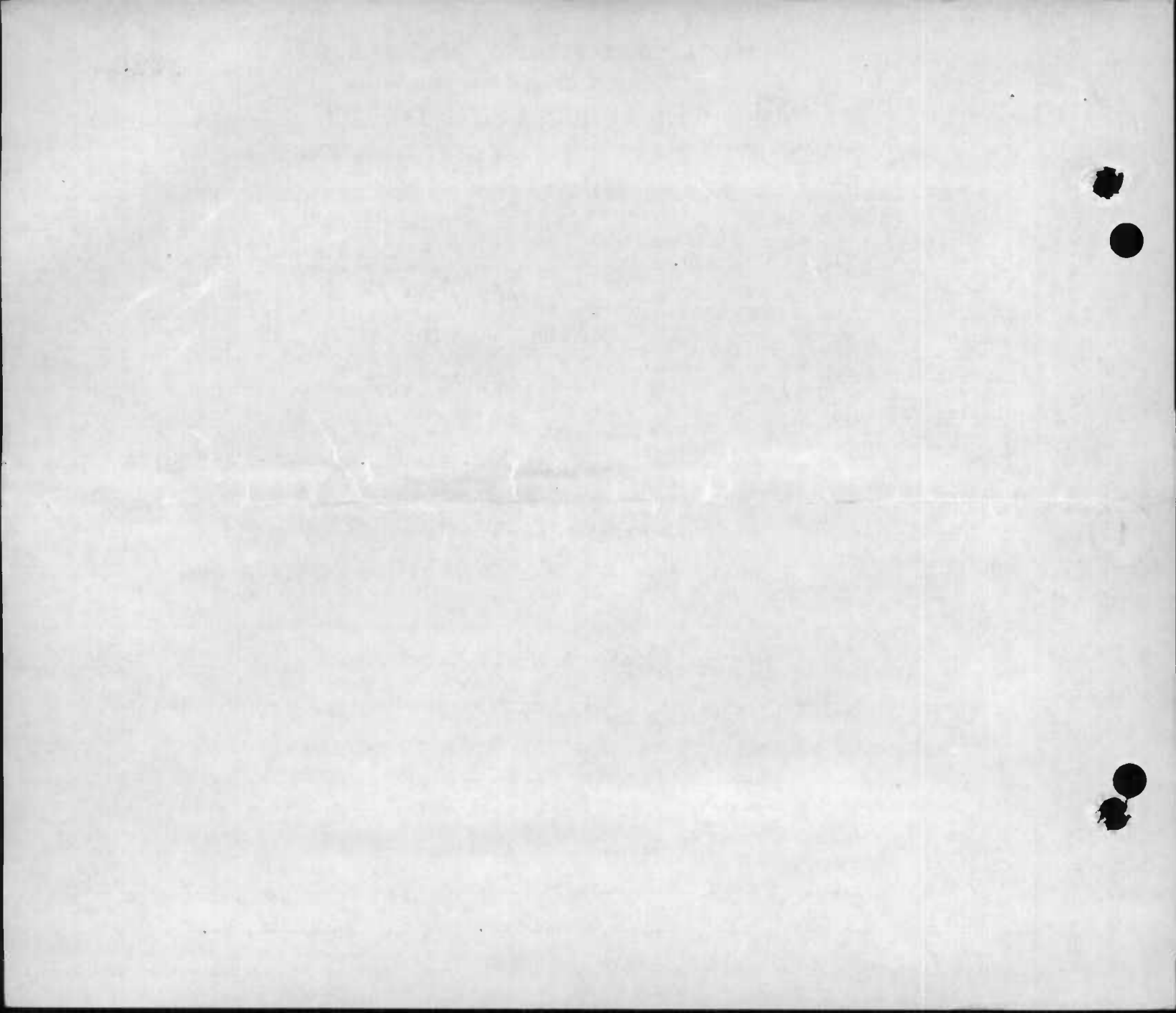
ADDRESS

8/16/56 **A. H. Hedrick** **Wm. J. Dickner & Sons - Balt. 7**

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8951

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08020 45

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 ESSEX</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>704 A BALLARD AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GEORGE P KUDZMA</u>				4. DATE OF DEATH <u>AUG. 9 19 56</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 22-1912</u>	
9. AGE (In years last birthday) <u>44 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REPAIRMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>P. R. R.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO., MD.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>JOHN KUDZMA</u>				14. MOTHER'S MAIDEN NAME <u>ELIZ. BUDRASWICZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>213-01-3676</u>		17. INFORMANT <u>SAM KUDZMA</u> Address <u>508 S. ROBINSON ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Jack Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 13-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTO NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>				24a. REC'D BY REGISTRAR <u>Edith Hurley</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

8051 - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. S.

AUG 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8952

CERTIFICATE OF DEATH

Reg. Dist. No.

08021

38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>54 Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Armstrong Nursing Home</i> <i>Regester & Sherwood Ave</i>		d. STREET ADDRESS <i>6730 Glenkirk Road</i>	
3. NAME OF DECEASED (Type or print) First <i>Mrs. Ida</i> Middle <i>S.</i> Last <i>Lambert</i>		4. DATE OF DEATH Month <i>August</i> Day <i>11th</i> Year <i>56</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 4, 1888</i>
9. AGE (In years last birthday) <i>68</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry Yienger</i>		14. MOTHER'S MAIDEN NAME <i>Minerva</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. William F. Lambert</i>		Address <i>6730 Glenkirk Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1999 METASTATIC CARCINOMA</i> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan</i> , 19 <i>56</i> , to <i>Aug 11</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Aug 7</i> , 19 <i>56</i> , and that death occurred at <i>2 A.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William A. Pillsbury</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>8/11/56</i>	
PHYSICIAN'S NAME (Type) <i>WILLIAM A. PILLSBURY</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/14/1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Park</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>Mark Grey</i> 24b. REGISTRAR'S SIGNATURE <i>Mark Grey</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8053 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08022

Reg. Dist. No. 80

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2 mos.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>14 Spring Grove State Hosp.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
3. NAME OF DECEASED (Type or print) <u>Frank J. LAVENDER</u>		d. STREET ADDRESS <u>2452 W. Baltimore St. - 2B</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-11-1871</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Chas Brown</u>		14. MOTHER'S MAIDEN NAME <u>dont know</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Rose Lavender - wife - Above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac failure</u> DUE TO (b) <u>Coronary vascular disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hastine Left femur.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>bed</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. fell from</u>	
20c. TIME OF INJURY Month, Day, Year <u>7-31-1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospit 21</u>		20f. (City or town) <u>Catonsville</u> (County) <u>Md.</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-27-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 29/56</u>		22b. DATE THEREOF <u>Aug 29/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) <u>unplaced</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>7. B. Wippert</u>		24a. REG'D BY REGISTRAR <u>1300 Entaw Place</u>	
24b. REGISTRAR'S SIGNATURE <u>Victor C. Hany</u>		DATE <u>8/28/56</u>	

18 BALTIMORE - DEPARTMENT OF HEALTH - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

AUG 29 1953

THE JOURNAL

1800 1801 1802 1803 1804 1805 1806 1807 1808 1809 1810 1811 1812 1813 1814 1815 1816 1817 1818 1819 1820 1821 1822 1823 1824 1825 1826 1827 1828 1829 1830 1831 1832 1833 1834 1835 1836 1837 1838 1839 1840 1841 1842 1843 1844 1845 1846 1847 1848 1849 1850 1851 1852 1853 1854 1855 1856 1857 1858 1859 1860 1861 1862 1863 1864 1865 1866 1867 1868 1869 1870 1871 1872 1873 1874 1875 1876 1877 1878 1879 1880 1881 1882 1883 1884 1885 1886 1887 1888 1889 1890 1891 1892 1893 1894 1895 1896 1897 1898 1899 1900 1901 1902 1903 1904 1905 1906 1907 1908 1909 1910 1911 1912 1913 1914 1915 1916 1917 1918 1919 1920 1921 1922 1923 1924 1925 1926 1927 1928 1929 1930 1931 1932 1933 1934 1935 1936 1937 1938 1939 1940 1941 1942 1943 1944 1945 1946 1947 1948 1949 1950 1951 1952 1953 1954 1955 1956 1957 1958 1959 1960 1961 1962 1963 1964 1965 1966 1967 1968 1969 1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7951
CERTIFICATE OF DEATH

08023
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b 42 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5013 Wilkens Ave		d. STREET ADDRESS 5013 Wilkens Ave	
3. NAME OF DECEASED (Type or print) First ROSE Middle B. Last LAWLER		4. DATE OF DEATH Month Aug. Day 9 Year 1956	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1883
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.	
11. BIRTHPLACE (State or foreign country) Phila. Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Thomas		14. MOTHER'S MAIDEN NAME Wilhelmia Eisenan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Mrs Julian Middleton, 5013 Wilkens Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis C.V. Disease (c) Auricular Fibrillation		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 2, 1956 to Aug 9, 1956 , that I last saw the deceased alive on Aug 9, 1956 , and that death occurred at 3.20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John F. Coolehan M.D.		ADDRESS (Street, city or town, state) 4201 Wilkens Ave	
DATE SIGNED 8/10/56			
PHYSICIAN'S NAME (Type) JOHN F. COOLEHAN		Baltimore 29, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 13/56	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witke		ADDRESS 4101 Edmondson Ave	
24a. REC'D BY REGISTRAR Dr. Geo M. Luffey		DATE 8/13/56	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John T. Williams</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Aug 14 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. DISEASE OR INJURY <i>Coronary Artery Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		11. SIGNATURE OF WITNESS <i>John T. Williams</i>		12. SIGNATURE OF DECEASED <i>John T. Williams</i>	
13. SIGNATURE OF REGISTRAR <i>John T. Williams</i>		14. SIGNATURE OF CLERK <i>John T. Williams</i>		15. SIGNATURE OF JURY <i>John T. Williams</i>	
16. SIGNATURE OF JURY <i>John T. Williams</i>		17. SIGNATURE OF JURY <i>John T. Williams</i>		18. SIGNATURE OF JURY <i>John T. Williams</i>	
19. SIGNATURE OF JURY <i>John T. Williams</i>		20. SIGNATURE OF JURY <i>John T. Williams</i>		21. SIGNATURE OF JURY <i>John T. Williams</i>	
22. SIGNATURE OF JURY <i>John T. Williams</i>		23. SIGNATURE OF JURY <i>John T. Williams</i>		24. SIGNATURE OF JURY <i>John T. Williams</i>	
25. SIGNATURE OF JURY <i>John T. Williams</i>		26. SIGNATURE OF JURY <i>John T. Williams</i>		27. SIGNATURE OF JURY <i>John T. Williams</i>	
28. SIGNATURE OF JURY <i>John T. Williams</i>		29. SIGNATURE OF JURY <i>John T. Williams</i>		30. SIGNATURE OF JURY <i>John T. Williams</i>	
31. SIGNATURE OF JURY <i>John T. Williams</i>		32. SIGNATURE OF JURY <i>John T. Williams</i>		33. SIGNATURE OF JURY <i>John T. Williams</i>	
34. SIGNATURE OF JURY <i>John T. Williams</i>		35. SIGNATURE OF JURY <i>John T. Williams</i>		36. SIGNATURE OF JURY <i>John T. Williams</i>	
37. SIGNATURE OF JURY <i>John T. Williams</i>		38. SIGNATURE OF JURY <i>John T. Williams</i>		39. SIGNATURE OF JURY <i>John T. Williams</i>	
40. SIGNATURE OF JURY <i>John T. Williams</i>		41. SIGNATURE OF JURY <i>John T. Williams</i>		42. SIGNATURE OF JURY <i>John T. Williams</i>	
43. SIGNATURE OF JURY <i>John T. Williams</i>		44. SIGNATURE OF JURY <i>John T. Williams</i>		45. SIGNATURE OF JURY <i>John T. Williams</i>	
46. SIGNATURE OF JURY <i>John T. Williams</i>		47. SIGNATURE OF JURY <i>John T. Williams</i>		48. SIGNATURE OF JURY <i>John T. Williams</i>	
49. SIGNATURE OF JURY <i>John T. Williams</i>		50. SIGNATURE OF JURY <i>John T. Williams</i>		51. SIGNATURE OF JURY <i>John T. Williams</i>	
52. SIGNATURE OF JURY <i>John T. Williams</i>		53. SIGNATURE OF JURY <i>John T. Williams</i>		54. SIGNATURE OF JURY <i>John T. Williams</i>	
55. SIGNATURE OF JURY <i>John T. Williams</i>		56. SIGNATURE OF JURY <i>John T. Williams</i>		57. SIGNATURE OF JURY <i>John T. Williams</i>	
58. SIGNATURE OF JURY <i>John T. Williams</i>		59. SIGNATURE OF JURY <i>John T. Williams</i>		60. SIGNATURE OF JURY <i>John T. Williams</i>	
61. SIGNATURE OF JURY <i>John T. Williams</i>		62. SIGNATURE OF JURY <i>John T. Williams</i>		63. SIGNATURE OF JURY <i>John T. Williams</i>	
64. SIGNATURE OF JURY <i>John T. Williams</i>		65. SIGNATURE OF JURY <i>John T. Williams</i>		66. SIGNATURE OF JURY <i>John T. Williams</i>	
67. SIGNATURE OF JURY <i>John T. Williams</i>		68. SIGNATURE OF JURY <i>John T. Williams</i>		69. SIGNATURE OF JURY <i>John T. Williams</i>	
70. SIGNATURE OF JURY <i>John T. Williams</i>		71. SIGNATURE OF JURY <i>John T. Williams</i>		72. SIGNATURE OF JURY <i>John T. Williams</i>	
73. SIGNATURE OF JURY <i>John T. Williams</i>		74. SIGNATURE OF JURY <i>John T. Williams</i>		75. SIGNATURE OF JURY <i>John T. Williams</i>	
76. SIGNATURE OF JURY <i>John T. Williams</i>		77. SIGNATURE OF JURY <i>John T. Williams</i>		78. SIGNATURE OF JURY <i>John T. Williams</i>	
79. SIGNATURE OF JURY <i>John T. Williams</i>		80. SIGNATURE OF JURY <i>John T. Williams</i>		81. SIGNATURE OF JURY <i>John T. Williams</i>	
82. SIGNATURE OF JURY <i>John T. Williams</i>		83. SIGNATURE OF JURY <i>John T. Williams</i>		84. SIGNATURE OF JURY <i>John T. Williams</i>	
85. SIGNATURE OF JURY <i>John T. Williams</i>		86. SIGNATURE OF JURY <i>John T. Williams</i>		87. SIGNATURE OF JURY <i>John T. Williams</i>	
88. SIGNATURE OF JURY <i>John T. Williams</i>		89. SIGNATURE OF JURY <i>John T. Williams</i>		90. SIGNATURE OF JURY <i>John T. Williams</i>	
91. SIGNATURE OF JURY <i>John T. Williams</i>		92. SIGNATURE OF JURY <i>John T. Williams</i>		93. SIGNATURE OF JURY <i>John T. Williams</i>	
94. SIGNATURE OF JURY <i>John T. Williams</i>		95. SIGNATURE OF JURY <i>John T. Williams</i>		96. SIGNATURE OF JURY <i>John T. Williams</i>	
97. SIGNATURE OF JURY <i>John T. Williams</i>		98. SIGNATURE OF JURY <i>John T. Williams</i>		99. SIGNATURE OF JURY <i>John T. Williams</i>	
100. SIGNATURE OF JURY <i>John T. Williams</i>		101. SIGNATURE OF JURY <i>John T. Williams</i>		102. SIGNATURE OF JURY <i>John T. Williams</i>	

RECEIVED
AUG 14 1956
BUREAU V. 2

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville rural				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Run Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Edward Last Lee, Jr.				4. DATE OF DEATH Month 8 Day 16 Year 56			
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-1892	9. AGE (In years last birthday) 63 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George E. Lee, Sr.				14. MOTHER'S MAIDEN NAME Emma Myers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-05-5771		17. INFORMANT Address Mrs. Clara A. Lee, Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Prostate 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH over 20 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 15, 1956 , to August 16, 1956 , that I last saw the deceased alive on August 15, 1956 , and that death occurred at 3:50 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter T. Kees		M.D. Cockeysville Md.		ADDRESS (Street, city or town, state) Cockeysville Md.		DATE SIGNED 16 August 56	
PHYSICIAN'S NAME (Type) Walter T. Kees							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-19-56		22c. NAME OF CEMETERY OR CREMATORY Gough's Methodist		22d. LOCATION (City, town, or county) (State) Cockeysville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks				ADDRESS Sparks, Md.		24a. REC'D BY REGISTRAR DATE 8/16/56	
				24b. REGISTRAR'S SIGNATURE Wm. J. Michael			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 26 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7947 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 0802541

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b 31 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 17 DUNDALK AVE.				d. STREET ADDRESS 17 DUNDALK AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHRISTIAN Middle (NMI) LENZ Last LENZ				4. DATE OF DEATH Month AUGUST Day 1 Year 1956 19			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 29, 1902	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer		10b. KIND OF BUSINESS OR INDUSTRY BLDG. CONSTR.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHRISTIAN G. LENZ				14. MOTHER'S MAIDEN NAME ELIZABETH HOEHN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-09-4174		17. INFORMANT Address VIOLA F. LENZ--SAME--WIDOW			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Hypertensive Card. Vasc. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO -Sym (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. Davis M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 8/2/56			
EXAMINER'S NAME (Type) M. B. Davis MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 4, 56		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN		22d. LOCATION (City, town, or county) (State) BALTO CO. MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Burke Brodley, Dundalk, Md.				24. REC'D BY REGISTRAR DATE AUG 3 1956		24b. REGISTRAR'S SIGNATURE Wm Kelly	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "M"]		AGE [Faint text, possibly "45"]		RACE [Faint text, possibly "W"]	
PLACE OF BIRTH [Faint text, possibly "BALTIMORE, MD."]		DATE OF BIRTH [Faint text, possibly "1910-01-01"]		PLACE OF DEATH [Faint text, possibly "BALTIMORE, MD."]		DATE OF DEATH [Faint text, possibly "1956-03-01"]	
OCCUPATION [Faint text, possibly "Carpenter"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		SIGNATURE OF EXAMINER [Faint signature]	
SIGNATURE OF NEXT OF KIN [Faint signature]		ADDRESS OF NEXT OF KIN [Faint text, possibly "123 Main St, Baltimore, MD."]		SIGNATURE OF WITNESS [Faint signature]		ADDRESS OF WITNESS [Faint text, possibly "456 Oak St, Baltimore, MD."]	

BUREAU V. S.

UG 3 1956

RECEIVED

8055

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8722 Summitt Ave</i>		d. STREET ADDRESS <i>8722 Summitt Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Marie Anna Lewis</i>		4. DATE OF DEATH Month Day Year <i>August 24th 19 56</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 2, 1894</i>
9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Emmert</i>		14. MOTHER'S MAIDEN NAME <i>Ella May Henry</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. John G. Fenwick</i> Address <i>8722 Summitt Ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive - Arteriosclerosis</i> <i>443X</i> DUE TO <i>C.V. Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Post Cerebral Hemorrhage</i> DUE TO (c) <i>Post Cerebral Hemorrhage</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>4/15</i> , 19 <i>56</i> , to <i>Aug 24</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>8/18</i> , 19 <i>56</i> , and that death occurred at <i>4:10 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Nathan Jarney</i> M.D.		ADDRESS (Street, city or town, state) <i>7101 Harford Rd.</i> DATE SIGNED <i>8/24/56</i>	
PHYSICIAN'S NAME (Type) <i>Nathan Jarney</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/27/1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road.</i>		24a. REC'D BY REGISTRAR <i>8/28/56</i>	24b. REGISTRAR'S SIGNATURE <i>Dr. A. M. Bacon</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
AUG 29 1956
BUREAU Y. S.

8056

CERTIFICATE OF DEATH

08027
Reg. Dist. No.

3

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>19yr3mt18dys</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk, Maryland</u>				d. STREET ADDRESS <u>8220 Cornwall Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Hilda</u> Middle <u>9</u> Last <u>Linthicum</u>				4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>19 56</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 30, 1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min. <u>58</u>		IF UNDER 24 HRS. Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min. <u>58</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John Rinehart</u>				14. MOTHER'S MAIDEN NAME <u>Louise Klemm</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>unknown</u>			
17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Lung Abscesses</u> DUE TO <u>undetermined</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Confluent lobular pneumonia</u> DUE TO <u>4 days</u> (c) <u>more</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug. 8,</u> 19 <u>56</u> , to <u>Aug. 16,</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Aug. 16,</u> 19 <u>56</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>8-16-56</u>							
ACTUAL SIGNATURE <u>Ellis S. Margolin</u> M.D.				PHYSICIAN'S NAME (Type) <u>ELLIS S. MARGOLIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>8/20/56</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>LODGE PARK</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. FAHEY</u>				24a. REC'D BY REGISTRAR <u>Aug 21 1956</u>			
ADDRESS <u>401 SUFFOLK Rd</u>				24b. REGISTRAR'S SIGNATURE <u>T. E. Harris</u>			

CERTIFICATE OF DEATH

8058

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES H. SMITH		Male		45		White		1910		Baltimore, Md.		1955		Baltimore, Md.		Heart Disease		Natural		J. H. Smith, M.D.		J. H. Smith, M.D.	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
Teacher		High School		Roman Catholic		Married		None		None		None		None		None		None		None		None	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	

RECEIVED
AUG 28 1956
BUREAU V. 8

1956
JUL 27
RECEIVED
AUG 28 1956
BUREAU V. 8

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 189111

8057

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) Towson OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS 6704 Tweedbrook Rd.		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) Towson OR TOWN STREET ADDRESS (If rural give location) 6704 Tweedbrook Rd.	
3. NAME OF DECEASED: (Type or Print) Michael Thomas Lyng		4. DATE (Month) (Day) (Year) OF DEATH: Aug. 22, 1956	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH: Sept. 19, 1906
9. AGE last birthday: 50 yrs		10. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life.) Attendant		10B. KIND OF BUSINESS OR INDUSTRY: Towson Esso.	
11. BIRTHPLACE (State or foreign country): Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Thomas F. Lyng		14. MOTHER'S MAIDEN NAME: Mary McGrath	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If Yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 577-05-2748	
17. INFORMANT & ADDRESS: Mrs. E.A. Dekker 6704 Tweedbrook R			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) 151X Carcinomatous secondary to Carcinoma of Stomach			
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8/11 , 19 55 to 8/17 , 19 56 , that I last saw the deceased alive on 8/17 , 19 56 , and that death occurred at 8:40 P.M. from the causes and on the date stated above			
SIGNATURE L. J. Stevens		DATE SIGNED 8/24/56	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Aug. 25, 56	
NAME OF CEMETERY OR CREMATORY New Cathedral		LOCATION (City, town, or county) (State) Balto. Md.	
DATE REC'D BY LOCAL REGISTRAR 8/24/56		24. FUNERAL DIRECTOR Paul Heemann ADDRESS 6067 Harford Rd.	

COMPTON
AVTIFY

8258

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Canada b. COUNTY Ontario	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Toronto	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 200 Garden Road		d. STREET ADDRESS 37 Standish Avenue	
3. NAME OF DECEASED (Type or print) DONALD BURGESS MacPhee		4. DATE OF DEATH August 6, 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 31, 1920
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman		10b. KIND OF BUSINESS OR INDUSTRY Consulting Engr.	
11. BIRTHPLACE (State or foreign country) Blackburn, England		12. CITIZEN OF WHAT COUNTRY? England	
13. FATHER'S NAME Burgess MacPhee		14. MOTHER'S MAIDEN NAME Marion Soanes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Mrs. Gertrude MacPhee		Address 37 Standish Ave., Toronto, Can.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/6 , 19 56 to 7/7 , 19 56 , that I last saw the deceased alive on 7/6 , 19 56 , and that death occurred at 3:34 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE George T. Gilmore M.D.		ADDRESS (Street, city or town, state) Lanham Bldg, Lutherville, Md.	
DATE SIGNED 7/7/56			
PHYSICIAN'S NAME (Type) GEORGE T. GILMORE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Aug. 9, 1956	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons		ADDRESS Towson, Md.	
24a. REC'D BY REGISTRAR Aug 9, 1956		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

2073

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1928		Baltimore, Md.		Natural		Heart Disease		Jan 15, 1973		10:00 AM		Home		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Marital Status		Previous Illnesses		Last Medical Examination		Last Hospital Admission		Last Physician's Visit		Last Prescription		Last X-ray		Last Blood Test		Last Urine Test		Last Stool Test		Last Sputum Test	
Teacher		Married		Hypertension		Jan 10, 1973		Jan 10, 1973		Jan 10, 1973		Jan 10, 1973		Jan 10, 1973		Jan 10, 1973		Jan 10, 1973		Jan 10, 1973		Jan 10, 1973	
Education		Religion		Race		Color		Height		Weight		Temperature		Pulse		Respiration		Blood Pressure		Heart Rate		Lung Capacity	
High School		Catholic		White		White		5' 10"		170 lbs		98.6°		72		18		120/80		70		1000 cc	
College		Protestant		Caucasian		Caucasian		5' 10"		170 lbs		98.6°		72		18		120/80		70		1000 cc	
Graduate		Episcopal		Caucasian		Caucasian		5' 10"		170 lbs		98.6°		72		18		120/80		70		1000 cc	
Postgraduate		Methodist		Caucasian		Caucasian		5' 10"		170 lbs		98.6°		72		18		120/80		70		1000 cc	
Professional		Jewish		Caucasian		Caucasian		5' 10"		170 lbs		98.6°		72		18		120/80		70		1000 cc	
Other		Muslim		Caucasian		Caucasian		5' 10"		170 lbs		98.6°		72		18		120/80		70		1000 cc	
None		Hindu		Caucasian		Caucasian		5' 10"		170 lbs		98.6°		72		18		120/80		70		1000 cc	
None		Buddhist		Caucasian		Caucasian		5' 10"		170 lbs		98.6°		72		18		120/80		70		1000 cc	
None		Sikh		Caucasian		Caucasian		5' 10"		170 lbs		98.6°		72		18		120/80		70		1000 cc	
None		Other		Caucasian		Caucasian		5' 10"		170 lbs		98.6°		72		18		120/80		70		1000 cc	

BUREAU V. I.

JUN 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8059 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **08020**

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE SPARKES POINT (19) (WORK)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore DUNDALK 22			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Co. Hospital				d. STREET ADDRESS 1820 Dummere Rd. #22			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LEO Middle CHARLES Last MAHON				4. DATE OF DEATH Month 8- Day 24 Year 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 JAN. 1918	
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months 1 Days 1		IF UNDER 24 HRS. Hours 1 Min. 56			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shearman				10b. KIND OF BUSINESS OR INDUSTRY STEEL MFR		11. BIRTHPLACE (State or foreign country) md	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME PATRICK MAHON				14. MOTHER'S MAIDEN NAME ROSA THOMPSON MAHON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WWII				16. SOCIAL SECURITY NO. 213-07-1976		17. INFORMANT MARTHA K. MAHON - SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. Davis, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8-24-56	
EXAMINER'S NAME (Type) M. B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-27-56		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN		22d. LOCATION (City, town, or county) (State) BALTO. CO. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Arthur Bradley, Dundalk, Md.				24a. REC'D BY REGISTRAR DATE 8/27/56		24b. REGISTRAR'S SIGNATURE Dr. Dawson L. Farber	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9551 2

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8060
CERTIFICATE OF DEATH

08030
Reg. Dist. No. 38

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Armagh Village (Balto. 12)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Armagh Village (Balto. 12)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 208 S. Tyrone Rd.				d. STREET ADDRESS 208 S. Tyrone Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MAY GROSS MANSFIELD				4. DATE OF DEATH Month AUG Day 1 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1873		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry S. Gross				14. MOTHER'S MAIDEN NAME Josephine Feelemyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Family records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTESTINAL CARCINOMA 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 9 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 3 , 19 56 to Aug. 1 , 19 56 that I last saw the deceased alive on Aug. 1 , 19 56 , and that death occurred at 3:45 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William A. Pillsbury M.D.				ADDRESS (Street, city or town, state) Towson, Md.		DATE SIGNED 8/1/56	
PHYSICIAN'S NAME (Type) WILLIAM A. PILLSBURY							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 4, 1956		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John Burr Somo				ADDRESS Towson, Md.		24a. REC'D BY REGISTRAR Aug 4, 1956	
				24b. REGISTRAR'S SIGNATURE Mabel C. Gray			

CERTIFICATE OF DEATH

DECEASED NAME JOHN J. ... RESIDENCE 123 ... CITY BOSTON STATE MASSACHUSETTS		DATE OF DEATH ... TIME ...	
SEX ... AGE ...		OCCUPATION ...	
CAUSE OF DEATH ...		PLACE OF DEATH ...	
SIGNATURE OF PHYSICIAN ...		SIGNATURE OF REGISTRAR ...	
CERTIFICATE NO. ...		DATE OF REGISTRATION ...	

BUREAU Y. 1

AUG 5 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7952

CERTIFICATE OF DEATH

08031

Reg. Dist. No. 47

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>ARBUTUS</u>		<u>4 months</u>		TOWN <u>ARBUTUS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1121 ELM Rd</u>				STREET ADDRESS (If rural give location) <u>1121 ELM Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARY</u>		(Middle) <u>F.</u>		(Last) <u>MASSEL</u>		(Month) (Day) (Year) <u>Aug. 19, 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>APRIL 5, 1887</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George DORSEY</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET M. Lee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>MR. WILLIAM MASSEL</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
175x IMMEDIATE CAUSE (A) <u>Carcinoma (ovarian) with metastases</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 mo</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>11 April 56</u>		19b. MAJOR FINDINGS OF OPERATION <u>generalized carcinomatosis from ovary</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>14 Dec. 50</u> to <u>19 Aug. 56</u> , that I last saw the deceased alive on <u>18 Aug. 56</u> , and that death occurred at <u>5 A.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Emil H. Henning Jr</u>				ADDRESS (Street, city, town, state) <u>601 Winans Way, Baltimore</u>		DATE SIGNED <u>20 Aug 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Aug 22, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK CEM.</u>		LOCATION (city, town, or county) (State) <u>BALTO MARYLAND</u>	
24. REC'D BY REGISTRAR <u>Dr. Geo M. Heffer</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>G. Truman Schuch</u>		ADDRESS <u>3512 Fredauch Ave. (29)</u>	
DATE <u>AUG 22 1956</u>							

CERTIFICATE OF DEATH

W-2-000-10

1. NAME OF DECEASED (PRINT OR TYPE)

LAST NAME

FIRST NAME

MIDDLE NAME

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

DATE OF EXAMINATION

PLACE OF EXAMINATION

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

2. MEDICAL CERTIFICATION

3. SIGNATURE OF DECEASED

4. SIGNATURE OF WITNESSES

5. SIGNATURE OF PHYSICIAN

6. SIGNATURE OF CLERK

7. SIGNATURE OF REGISTRAR

8. SIGNATURE OF JUDGE

9. SIGNATURE OF SHERIFF

10. SIGNATURE OF CORONER

11. SIGNATURE OF DISTRICT ATTORNEY

12. SIGNATURE OF COUNTY CLERK

13. SIGNATURE OF CITY CLERK

14. SIGNATURE OF TOWN CLERK

15. SIGNATURE OF VILLAGE CLERK

16. SIGNATURE OF POST OFFICE CLERK

17. SIGNATURE OF SCHOOL CLERK

18. SIGNATURE OF CHURCH CLERK

19. SIGNATURE OF SYNAGOGUE CLERK

20. SIGNATURE OF MOSQUE CLERK

21. SIGNATURE OF TEMPLE CLERK

22. SIGNATURE OF CHAPEL CLERK

23. SIGNATURE OF GYMNASIUM CLERK

24. SIGNATURE OF YOUTH CENTER CLERK

25. SIGNATURE OF SENIOR CENTER CLERK

26. SIGNATURE OF NURSING HOME CLERK

27. SIGNATURE OF HOSPITAL CLERK

28. SIGNATURE OF LABORATORY CLERK

29. SIGNATURE OF PHARMACY CLERK

30. SIGNATURE OF OPTICIAN CLERK

31. SIGNATURE OF DENTIST CLERK

32. SIGNATURE OF VETERINARIAN CLERK

33. SIGNATURE OF ARCHITECT CLERK

34. SIGNATURE OF ENGINEER CLERK

35. SIGNATURE OF SURVEYOR CLERK

BUREAU V. S.

AUG 22 1956

RECEIVED

1. NAME OF DECEASED (PRINT OR TYPE)
2. MEDICAL CERTIFICATION
3. SIGNATURE OF DECEASED
4. SIGNATURE OF WITNESSES
5. SIGNATURE OF PHYSICIAN
6. SIGNATURE OF CLERK
7. SIGNATURE OF REGISTRAR
8. SIGNATURE OF JUDGE
9. SIGNATURE OF SHERIFF
10. SIGNATURE OF CORONER
11. SIGNATURE OF DISTRICT ATTORNEY
12. SIGNATURE OF COUNTY CLERK
13. SIGNATURE OF CITY CLERK
14. SIGNATURE OF TOWN CLERK
15. SIGNATURE OF VILLAGE CLERK
16. SIGNATURE OF POST OFFICE CLERK
17. SIGNATURE OF SCHOOL CLERK
18. SIGNATURE OF CHURCH CLERK
19. SIGNATURE OF SYNAGOGUE CLERK
20. SIGNATURE OF MOSQUE CLERK
21. SIGNATURE OF TEMPLE CLERK
22. SIGNATURE OF CHAPEL CLERK
23. SIGNATURE OF GYMNASIUM CLERK
24. SIGNATURE OF YOUTH CENTER CLERK
25. SIGNATURE OF SENIOR CENTER CLERK
26. SIGNATURE OF NURSING HOME CLERK
27. SIGNATURE OF HOSPITAL CLERK
28. SIGNATURE OF LABORATORY CLERK
29. SIGNATURE OF PHARMACY CLERK
30. SIGNATURE OF OPTICIAN CLERK
31. SIGNATURE OF DENTIST CLERK
32. SIGNATURE OF VETERINARIAN CLERK
33. SIGNATURE OF ARCHITECT CLERK
34. SIGNATURE OF ENGINEER CLERK
35. SIGNATURE OF SURVEYOR CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8061

CERTIFICATE OF DEATH

08032

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville rural		c. LENGTH OF STAY IN 1b life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville rural		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Falls Rd.	
d. STREET ADDRESS Falls Rd.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stella Middle Mabel Last McCaslin		4. DATE OF DEATH 8 - 18 - 56 Day 19	
5. SEX female WHITE	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-17-1893
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 8 Days 18 Hours 56 Min.	IF UNDER 24 HRS. Hours 56 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Gartling	
14. MOTHER'S MAIDEN NAME Sophia Wittkopf		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. -----		17. INFORMANT Ridgeway A. McCaslin, Cockeysville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) -----		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/22/1954 to 8/18/1956 , that I last saw the deceased alive on July 26, 1956 , and that death occurred at 8 A M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 8/8/56	
ACTUAL SIGNATURE M. K. Quinn M.D.		1927 York Rd, TIMONIUM	
PHYSICIAN'S NAME (Type) M. KEVIN QUINN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-21-56	
22c. NAME OF CEMETERY OR CREMATORY Grace Methodist		22d. LOCATION (City, town, or county) (State) Falls Rd., Cockeysville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks		ADDRESS Sparks, Md.	
24a. REC'D BY REGISTRAR 8/20/56		24b. REGISTRAR'S SIGNATURE Wm. J. L. L. L.	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX Male		AGE 45	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH 1-15-1910		TIME OF DEATH 10:30 AM	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
DATE OF DEATH 1-15-1956		TIME OF DEATH 10:30 AM		PLACE OF DEATH [Faint text]	
SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF CLERK [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	

BUREAU V. 4

AUG 22 1956

RECEIVED

8062

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 114 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 27 d. STREET ADDRESS 604 Aldershot Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Also: Thomas First (NMI) Middle Morris Last MORRIS, SR. J. THOMAS (Type or print)				4. DATE OF DEATH Month August Day 15 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 22, 1884	
9. AGE (In years last birthday) 71 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Inspector		10b. KIND OF BUSINESS OR INDUSTRY City Government		11. BIRTHPLACE (State or foreign country) Troy, New York	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Thomas J. Morris			
14. MOTHER'S MAIDEN NAME Catherine Morgan				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I			
16. SOCIAL SECURITY NO. None				17. INFORMANT Address Clin. Rec., Vet. Adminis. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE WITH PULMONARY EDEMA 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS AND LUNG ABSCESS INTERVAL BETWEEN ONSET AND DEATH 6 HOURS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 23, 1956 , to August 15, 1956 , and that death occurred at 10:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 8/15/56 ACTUAL SIGNATURE A. G. Edwards PHYSICIAN'S NAME (Type) A. G. EDWARDS M.D., VAH, FORT HOWARD, MARYLAND 8-15-56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-17-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight Inc ADDRESS 6009 Harford Rd., Balto. Md.				24a. REC'D BY REGISTRAR 106 221050		24b. REGISTRAR'S SIGNATURE Dawson L. Farber	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF BIRTH		2. PLACE OF DEATH	
3. SEX		4. AGE	
5. OCCUPATION		6. CAUSE OF DEATH	
7. MANNER OF DEATH		8. DATE OF DEATH	
9. TIME OF DEATH		10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESSES		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF CORONER		14. SIGNATURE OF JURY	
15. SIGNATURE OF JUDGE		16. SIGNATURE OF CLERK	
17. SIGNATURE OF SHERIFF		18. SIGNATURE OF DEPUTY SHERIFF	
19. SIGNATURE OF TOWNSHIP CLERK		20. SIGNATURE OF COUNTY CLERK	
21. SIGNATURE OF STATE CLERK		22. SIGNATURE OF FEDERAL CLERK	
23. SIGNATURE OF MARSHAL		24. SIGNATURE OF JAILER	
25. SIGNATURE OF PRISONER		26. SIGNATURE OF GUARD	
27. SIGNATURE OF WARDEN		28. SIGNATURE OF DEPUTY WARDEN	
29. SIGNATURE OF CHIEF OF POLICE		30. SIGNATURE OF DEPUTY CHIEF OF POLICE	
31. SIGNATURE OF SHERIFF		32. SIGNATURE OF DEPUTY SHERIFF	
33. SIGNATURE OF TOWNSHIP CLERK		34. SIGNATURE OF COUNTY CLERK	
35. SIGNATURE OF STATE CLERK		36. SIGNATURE OF FEDERAL CLERK	
37. SIGNATURE OF MARSHAL		38. SIGNATURE OF JAILER	
39. SIGNATURE OF PRISONER		40. SIGNATURE OF GUARD	
41. SIGNATURE OF WARDEN		42. SIGNATURE OF DEPUTY WARDEN	
43. SIGNATURE OF CHIEF OF POLICE		44. SIGNATURE OF DEPUTY CHIEF OF POLICE	
45. SIGNATURE OF SHERIFF		46. SIGNATURE OF DEPUTY SHERIFF	
47. SIGNATURE OF TOWNSHIP CLERK		48. SIGNATURE OF COUNTY CLERK	
49. SIGNATURE OF STATE CLERK		50. SIGNATURE OF FEDERAL CLERK	
51. SIGNATURE OF MARSHAL		52. SIGNATURE OF JAILER	
53. SIGNATURE OF PRISONER		54. SIGNATURE OF GUARD	
55. SIGNATURE OF WARDEN		56. SIGNATURE OF DEPUTY WARDEN	
57. SIGNATURE OF CHIEF OF POLICE		58. SIGNATURE OF DEPUTY CHIEF OF POLICE	
59. SIGNATURE OF SHERIFF		60. SIGNATURE OF DEPUTY SHERIFF	
61. SIGNATURE OF TOWNSHIP CLERK		62. SIGNATURE OF COUNTY CLERK	
63. SIGNATURE OF STATE CLERK		64. SIGNATURE OF FEDERAL CLERK	
65. SIGNATURE OF MARSHAL		66. SIGNATURE OF JAILER	
67. SIGNATURE OF PRISONER		68. SIGNATURE OF GUARD	
69. SIGNATURE OF WARDEN		70. SIGNATURE OF DEPUTY WARDEN	
71. SIGNATURE OF CHIEF OF POLICE		72. SIGNATURE OF DEPUTY CHIEF OF POLICE	
73. SIGNATURE OF SHERIFF		74. SIGNATURE OF DEPUTY SHERIFF	
75. SIGNATURE OF TOWNSHIP CLERK		76. SIGNATURE OF COUNTY CLERK	
77. SIGNATURE OF STATE CLERK		78. SIGNATURE OF FEDERAL CLERK	
79. SIGNATURE OF MARSHAL		80. SIGNATURE OF JAILER	
81. SIGNATURE OF PRISONER		82. SIGNATURE OF GUARD	
83. SIGNATURE OF WARDEN		84. SIGNATURE OF DEPUTY WARDEN	
85. SIGNATURE OF CHIEF OF POLICE		86. SIGNATURE OF DEPUTY CHIEF OF POLICE	
87. SIGNATURE OF SHERIFF		88. SIGNATURE OF DEPUTY SHERIFF	
89. SIGNATURE OF TOWNSHIP CLERK		90. SIGNATURE OF COUNTY CLERK	
91. SIGNATURE OF STATE CLERK		92. SIGNATURE OF FEDERAL CLERK	
93. SIGNATURE OF MARSHAL		94. SIGNATURE OF JAILER	
95. SIGNATURE OF PRISONER		96. SIGNATURE OF GUARD	
97. SIGNATURE OF WARDEN		98. SIGNATURE OF DEPUTY WARDEN	
99. SIGNATURE OF CHIEF OF POLICE		100. SIGNATURE OF DEPUTY CHIEF OF POLICE	

RECEIVED
AUG 28 1956
BUREAU V. 2

7953

CERTIFICATE OF DEATH

Reg. Dist. No.

42

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4813 Benson Ave.				d. STREET ADDRESS 4813 Benson Ave.			
3. NAME OF DECEASED (Type or print) John C. Merson				4. DATE OF DEATH August 4, 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 5, 1888	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY							
13. FATHER'S NAME Charles E. Merson				14. MOTHER'S MAIDEN NAME Mary E. Roemer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Address Mrs. Katherine Merson 4813 Benson Ave.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest secondary to Complete Heart Block & Adams Stokes Syndrome DUE TO (b) 433.0 DUE TO (c) Adams Stokes Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive A.S. C.V. D.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 1953 , to Aug 4, 1956 , that I last saw the deceased alive on Aug 2nd , 19 56 , and that death occurred at 1:57 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John C. Healy M.D.				ADDRESS (Street, city or town, state) Palethorpe 27, Md			
PHYSICIAN'S NAME (Type) John C. Healy				DATE SIGNED 8/4/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 7, 1956		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ambrase, Inc. 1328 Sulphur Sp. Rd.				24a. REC'D BY REGISTRAR DATE Aug 7 1956		24b. REGISTRAR'S SIGNATURE Dr. Geo M. Kueffer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7552

Baltimore Maryland

Arbitus

4813 Hanson Ave.

John G. Hanson

Male White January 3, 1888 68

Partner Self Employed Maryland

Charles E. Hanson Mary E. Roemer

Mrs. Katherine Hanson 4813 Hanson Ave.

BUREAU V. S.

AUG 7 1956

RECEIVED

Baltimore Aug. 7, 1956 London Park

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8063

CERTIFICATE OF DEATH

Reg. Dist. No. 08035 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mission Helpers of the Sacred Heart Convent,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. NAME OF DECEASED (Type or print) Sister Mary Eucharist Mulkerin		4. DATE OF DEATH August 21 19 56	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		10b. KIND OF BUSINESS OR INDUSTRY Convent	9. AGE (In years last birthday) 87
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Mulkerin		14. MOTHER'S MAIDEN NAME Mary Flaherty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Convent Records,		Address 1001 W. Joppa Road, Towson	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 4 YRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1954 , to Aug. 21, 1956 , that I last saw the deceased alive on Aug 20, 1956 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Pillsbury M.D.		DATE SIGNED 8/22/56	
PHYSICIAN'S NAME (Type) WILLIAM A. PILLSBURY		Dr. William A. Pillsbury, Timonium, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 24, 1956	22c. NAME OF CEMETERY OR CREMATORY Convent Cemetery	22d. LOCATION (City, town, or county) (State) Towson, Balto. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE G. Vernon Lemmon		24a. REC'D BY REGISTRAR 23 1956	24b. REGISTRAR'S SIGNATURE Mabel Gray

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
[Illegible]		[Illegible]		[Illegible]	
SEX		AGE		RACE	
[Illegible]		[Illegible]		[Illegible]	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
[Illegible]		[Illegible]		[Illegible]	
MANNER OF DEATH		OCCUPATION		EDUCATION	
[Illegible]		[Illegible]		[Illegible]	
MARITAL STATUS		RELIGION		SPECIAL INSTRUCTIONS	
[Illegible]		[Illegible]		[Illegible]	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
[Illegible]		[Illegible]		[Illegible]	
DATE		TIME		PLACE	
[Illegible]		[Illegible]		[Illegible]	

BUREAU Y. 3

AUG 23 1956

RECEIVED

UNIT 1
[Illegible text]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 08036

8064 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY <u>Ellicott City</u>		CITY <u>Ellicott City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Ellicott City</u>		<u>45 yrs.</u>		TOWN <u>Ellicott City</u>		TOWN <u>Ellicott City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Westchester Avenue</u>				STREET ADDRESS (If rural give location) <u>Westchester Ave.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ANNA MARIE MURK</u>				<u>Aug. 19, 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 25, 1894</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rewinder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Woolen Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>August Affeldt</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Hepner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-24-4509</u>		17. INFORMANT & ADDRESS <u>City, Md. Edward P. Murk Westchester Ave. Ellicott</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
176X IMMEDIATE CAUSE (A) <u>Primary Carcinoma of Vulva. General</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 mos.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinomatosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 3, 1956, to Aug. 10, 1956, that I last saw the deceased alive on Aug. 10, 1956, and that death occurred at 6 P.M. from the causes and on the date stated above.							
SIGNATURE <u>George E. Buntorf</u>		M.D. <u>Ellicott City, Md.</u>		DATE SIGNED <u>8/20/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/22/56</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>8/21/56</u>		REGISTRAR'S SIGNATURE <u>V. E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Bone</u>		ADDRESS <u>Catonsville, Md.</u>	

RECEIVED

AUG 22 1956

BUREAU V. 2

1. NAME OF DECEASED		2. PLACE OF BIRTH	
3. SEX		4. RACE	
5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH	
9. MEDICAL EXAMINATION		10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESSES		12. SIGNATURE OF OFFICIAL	
13. SIGNATURE OF OFFICIAL		14. SIGNATURE OF OFFICIAL	
15. SIGNATURE OF OFFICIAL		16. SIGNATURE OF OFFICIAL	
17. SIGNATURE OF OFFICIAL		18. SIGNATURE OF OFFICIAL	
19. SIGNATURE OF OFFICIAL		20. SIGNATURE OF OFFICIAL	
21. SIGNATURE OF OFFICIAL		22. SIGNATURE OF OFFICIAL	
23. SIGNATURE OF OFFICIAL		24. SIGNATURE OF OFFICIAL	
25. SIGNATURE OF OFFICIAL		26. SIGNATURE OF OFFICIAL	
27. SIGNATURE OF OFFICIAL		28. SIGNATURE OF OFFICIAL	
29. SIGNATURE OF OFFICIAL		30. SIGNATURE OF OFFICIAL	
31. SIGNATURE OF OFFICIAL		32. SIGNATURE OF OFFICIAL	
33. SIGNATURE OF OFFICIAL		34. SIGNATURE OF OFFICIAL	
35. SIGNATURE OF OFFICIAL		36. SIGNATURE OF OFFICIAL	
37. SIGNATURE OF OFFICIAL		38. SIGNATURE OF OFFICIAL	
39. SIGNATURE OF OFFICIAL		40. SIGNATURE OF OFFICIAL	
41. SIGNATURE OF OFFICIAL		42. SIGNATURE OF OFFICIAL	
43. SIGNATURE OF OFFICIAL		44. SIGNATURE OF OFFICIAL	
45. SIGNATURE OF OFFICIAL		46. SIGNATURE OF OFFICIAL	
47. SIGNATURE OF OFFICIAL		48. SIGNATURE OF OFFICIAL	
49. SIGNATURE OF OFFICIAL		50. SIGNATURE OF OFFICIAL	
51. SIGNATURE OF OFFICIAL		52. SIGNATURE OF OFFICIAL	
53. SIGNATURE OF OFFICIAL		54. SIGNATURE OF OFFICIAL	
55. SIGNATURE OF OFFICIAL		56. SIGNATURE OF OFFICIAL	
57. SIGNATURE OF OFFICIAL		58. SIGNATURE OF OFFICIAL	
59. SIGNATURE OF OFFICIAL		60. SIGNATURE OF OFFICIAL	
61. SIGNATURE OF OFFICIAL		62. SIGNATURE OF OFFICIAL	
63. SIGNATURE OF OFFICIAL		64. SIGNATURE OF OFFICIAL	
65. SIGNATURE OF OFFICIAL		66. SIGNATURE OF OFFICIAL	
67. SIGNATURE OF OFFICIAL		68. SIGNATURE OF OFFICIAL	
69. SIGNATURE OF OFFICIAL		70. SIGNATURE OF OFFICIAL	
71. SIGNATURE OF OFFICIAL		72. SIGNATURE OF OFFICIAL	
73. SIGNATURE OF OFFICIAL		74. SIGNATURE OF OFFICIAL	
75. SIGNATURE OF OFFICIAL		76. SIGNATURE OF OFFICIAL	
77. SIGNATURE OF OFFICIAL		78. SIGNATURE OF OFFICIAL	
79. SIGNATURE OF OFFICIAL		80. SIGNATURE OF OFFICIAL	
81. SIGNATURE OF OFFICIAL		82. SIGNATURE OF OFFICIAL	
83. SIGNATURE OF OFFICIAL		84. SIGNATURE OF OFFICIAL	
85. SIGNATURE OF OFFICIAL		86. SIGNATURE OF OFFICIAL	
87. SIGNATURE OF OFFICIAL		88. SIGNATURE OF OFFICIAL	
89. SIGNATURE OF OFFICIAL		90. SIGNATURE OF OFFICIAL	
91. SIGNATURE OF OFFICIAL		92. SIGNATURE OF OFFICIAL	
93. SIGNATURE OF OFFICIAL		94. SIGNATURE OF OFFICIAL	
95. SIGNATURE OF OFFICIAL		96. SIGNATURE OF OFFICIAL	
97. SIGNATURE OF OFFICIAL		98. SIGNATURE OF OFFICIAL	
99. SIGNATURE OF OFFICIAL		100. SIGNATURE OF OFFICIAL	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8965

CERTIFICATE OF DEATH

08037 31

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balt</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>PA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gwynn Oak</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>YORK PA.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HUGSBURG HOME</u>		d. STREET ADDRESS <u>?</u>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>KATE</u> Last <u>MYERS</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>19</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 25, 1868</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>YORK Co. PA.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>HENRY H MEYERS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZ WAND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>RECORDS HVB HOME CAMPFIELD</u>		Address <u>PA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Arterio-sclerotic C. V. D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with Hypertension</u> (c) <u>Generalized Arterio-sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/14</u> , 19 <u>56</u> , to <u>8/30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/16</u> , 19 <u>56</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl L. Chambers</u> M.D.		ADDRESS (Street, city or town, state) <u>4108 Liberty Hts Baltimore Md.</u>	
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>		DATE SIGNED <u>8-30-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 21, 56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		22d. LOCATION (City, town, or county) (State) <u>YORK PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PAUL HEEHANN</u>		ADDRESS <u>6067 Haywood Rd</u>	
24a. REC'D BY REGISTRAR <u>Aug 21 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. E. Meador</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Aug 21 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08038 ✓

Reg. Dist. No. 30

8066

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Fr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville		c. LENGTH OF STAY IN 1b 1yr 5m 6dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland		1615.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 4201 Oglethorpe Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marion Middle Annette Last Newcomb		4. DATE OF DEATH Month August Day 22 Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1879
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) file clerk		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Simon D. Newcomb		14. MOTHER'S MAIDEN NAME Mary Catelin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown --		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Acute Cardiac Failure DUE TO (b) Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) 902.7 fracture right femur PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) from chair to the floor by another patient on 6-14-56.			
INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Patient was pushed	
20c. TIME OF INJURY Month, Day, Year 7:40 AM June 14 1956		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/> Hospital	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Catonsville 28, Maryland		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E.O. S.M. KUIEFFER		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E.O. S.M. KUIEFFER		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8-22-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/25/56	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gascho		ADDRESS Hyattsville Md	
24a. REC'D BY REGISTRAR Victor C. Harry		24b. REGISTRAR'S SIGNATURE Victor C. Harry	
DATE 8/27/56			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 31

1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08039

8067

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN b 18 Hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH First Middle Last LEO J. NEWELL				4. DATE OF DEATH Month Day Year August 22 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 21, 1895	
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster				10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Joseph Newell				14. MOTHER'S MAIDEN NAME Mary Cordell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease with Congestive Failure - 6 Weeks duration							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3:40PM 9:40AM	
20f. (City or town) (County) (State) Baltimore, Maryland							
21. I certify that I attended the deceased from August 21, 1956 , to August 22, 1956 , that death occurred on the date stated above, and that death occurred at 9:40A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VA HOSPITAL, FORT HOWARD, MARYLAND 8/22/56							
ACTUAL SIGNATURE Irving Freeman M.D. VA HOSPITAL, FORT HOWARD, MARYLAND 8/22/56							
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Acting Chief, Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-25-56		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke				ADDRESS 4101 Edmondson Ave., Balto		24a. REC'D BY REGISTRAR 8/28/56	
24b. REGISTRAR'S SIGNATURE Dr. Dawson S. Parker							

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		45		JAN 15 1910		BALTIMORE		MD		MD		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
LABORER		HEART DISEASE		NATURAL		JAN 20 1956		BALTIMORE		MD		MD		USA	
EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS ILLNESS		HISTORY OF DRUGS		HISTORY OF ALCOHOL		HISTORY OF TOBACCO		HISTORY OF OTHER	
HIGH SCHOOL		METHODIST		MARRIED		NONE		NONE		NONE		NONE		NONE	
SIGNED AND SWORN TO		ATTEST		DECEASED'S SIGNATURE		DECEASED'S ADDRESS		DECEASED'S CITY		DECEASED'S STATE		DECEASED'S COUNTRY		DECEASED'S ZIP	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. 1

1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8068

CERTIFICATE OF DEATH

Reg. Dist. No.

080404

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 58 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
f. STREET ADDRESS 1417 BATTERY AVENUE				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle E. Last Norris				4. DATE OF DEATH Month August Day 17 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-27-92	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK & WEIGHER				10b. KIND OF BUSINESS OR INDUSTRY STEAMSHIP CO.			
13. FATHER'S NAME JOHN J. NORRIS				14. MOTHER'S MAIDEN NAME ELIZABETH HUGHES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES <input checked="" type="checkbox"/> WW-1				16. SOCIAL SECURITY NO. 215-10-6982			
17. INFORMANT CLIN. REC., VET. ADM. HOSP., FORT HOWARD, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DISSECTING ANEURYSM OF THE AORTA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 - 3 WEEKS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) POSTERIOR MYOCARDIAL INFARCTION-3 MONTHS; CEREBRAL EMBOLUS-2 MONTHS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) FORT HOWARD, MARYLAND				20g. (County) BALTIMORE		20h. (State) MARYLAND	
21. I certify that I attended the deceased from JUNE 20 , 19 56 , to AUGUST 17 , 19 56 , and that death occurred at 3:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. J. Papastrat M.D.				DATE SIGNED 8-17-56			
PHYSICIAN'S NAME (Type) CONSTANTINE J. PAPASTRAT				M.D. FORT HOWARD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-21-56		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN FAHEY FUNERAL HOME				24a. REC'D BY REGISTRAR 1318 Light St. Baltimore, Md.			
24b. REGISTRAR'S SIGNATURE 1318 Light St. Baltimore, Md.				24c. REC'D BY REGISTRAR AUG 21 1956			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8069

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glyndon</u>		c. LENGTH OF STAY IN 1b <u>7 wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9 Waugh Ave.</u>				d. STREET ADDRESS <u>4511 Homer Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Irwin</u> Last <u>North</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>13</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 15, 1863</u>		9. AGE (In years) <u>92</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James L. Irwin</u>				14. MOTHER'S MAIDEN NAME <u>Laura V. Wheeler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Place, Balto.</u> <u>Mrs. William Lewis, 22 E. Mt. Vernon</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis-</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of Rt. Breast</u> (c) <u>170x</u> DUE TO (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>none</u> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>none</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>D. D. Caples</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner & Sons, Balto. 17, Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 16 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Elise</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

AUG 17 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

8070

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 353 Townsend Road		d. STREET ADDRESS 353 Townsend Road	
3. NAME OF DECEASED (Type or print) First BETTY Middle NOVAK Last NOVAK		4. DATE OF DEATH Month August Day 9 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1859
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 97
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Meka		14. MOTHER'S MAIDEN NAME Don't know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Anna R. Rodgers		Address 20 Seabright Ave. 22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) G.I. hemorrhage, dehydration 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 days Several years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June , 19 56 , to Aug. 9 , 19 56 , that I last saw the deceased alive on Aug 7, 19 56 , and that death occurred at 1130A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. PLATT, M.D.		ADDRESS (Street, city or town, state) 434 Eastern Ave Essex md.	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 11, 1956	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home		ADDRESS 2112 Dundalk Ave-22	
24a. REC'D BY REGISTRAR AUG 13 1956		24b. REGISTRAR'S SIGNATURE Edith Hurley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

Aug 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08043

Reg. Dist. No. 45

8971

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>		d. STREET ADDRESS <u>353 Townsend Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>J.</u> Last <u>Norak</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 19-1882</u> 73 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Clerk.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fish Market</u>	9. AGE (In years last birthday) <u>73</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John H Norak</u>		14. MOTHER'S MAIDEN NAME <u>Betty McK2</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>18803-68054-</u> 17. INFORMANT <u>Killa N. Norak</u> Address <u>353 Townsend Rd. Essex</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>menia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebro-vascular hemorrhage</u> DUE TO (c) <u>Cerebral vascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 70</u> <u>8 70</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec.</u> , 19 <u>55</u> , to <u>8/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/1</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>434 EASTERN Ave.</u> DATE SIGNED <u>8/2/56</u> ACTUAL SIGNATURE <u>J. Platt</u> M.D. <u>Essex, Md</u> PHYSICIAN'S NAME (Type) <u>J. PLATT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>8/18/56</u>	<u>Oak Lawn</u>	<u>Baltimore Co.</u> <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook Inc. 1217 St Paul St.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>AUG 20 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Edith Huxley</u>

CERTIFICATE OF DEATH

3011

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
John Doe		Male		45		1910		Maryland		Baltimore		Heart Disease		1955		10:00 AM		Home		Natural		Dr. J. Smith		J. Doe		J. Doe	
Occupation		Marital Status		Education		Religion		Race		Color		Previous Illnesses		Last Medical Examination		Last Medical Advice		Last Medical Treatment		Last Medical Examination		Last Medical Advice		Last Medical Treatment		Last Medical Examination	
Teacher		Married		High School		Catholic		White		White		None		1954		1955		1955		1955		1955		1955		1955	
Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant		Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Informant	
1955		10:00 AM		Home		Natural		Dr. J. Smith		J. Doe		J. Doe		1955		10:00 AM		Home		Natural		Dr. J. Smith		J. Doe		J. Doe	

BUREAU V. 5

AUG 20 1956

RECEIVED

Wm. G. Smith, Jr. 1955 11 21 1955

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8072

CERTIFICATE OF DEATH

08044

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE CO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 27	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2818 Michigan Ave		d. STREET ADDRESS 2818 Michigan Ave	
3. NAME OF DECEASED (Type or print) ANNA M O'CONNELL		4. DATE OF DEATH August 10, 1956	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1873
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Lotz		14. MOTHER'S MAIDEN NAME Margaret Bost	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Helen M. O'Connell		Address 2818 Michigan Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X HYPERTENSIVE CARDIO-VASCULAR DISEASE DUE TO (b) PULMONARY EDEMA DUE TO (c) ARTERIOSCLEROSIS - CHOLECYSTITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/11 , 19 56 , to 8/10 , 19 56 , that I last saw the deceased alive on 8/10 , 19 56 , and that death occurred at 11 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Shaw M.D.		ADDRESS (Street, city or town, state) 5800 EDWARDS AVE	
PHYSICIAN'S NAME (Type) JOHN H. SHAW M.D.		DATE SIGNED 8/11/56	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/13/56	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook inc		ADDRESS 1217 St. Paul Street Balto	
24a. REC'D BY REGISTRAR 13 1956		24b. REGISTRAR'S SIGNATURE Dr. Geo. M. Huffer	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JULY 13, 1956	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
MARRIAGE		OCCUPATION	
M		C	
PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE, MD		BALTIMORE, MD	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
IMMEDIATE CAUSE		FURTHER CAUSE	
CORONARY THROMBOSIS		HYPERTENSION	
PREVIOUS ILLNESS		PREVIOUS SURGERY	
NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS	
DATE		DATE	
JULY 13, 1956		JULY 13, 1956	

BUREAU V. 1

JUL 13 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8073 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

48045
08045

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1mt 18dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
3. NAME OF DECEASED (Type or print) First Marie Middle Virginia Last Patterson		4. DATE OF DEATH Month August Day 31 Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1876
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Patterson		14. MOTHER'S MAIDEN NAME Rebecca McComes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT James W. Patterson - RockSpring Road - Belair		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 903.7 DUE TO Coronary vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fracture of right hip		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Epic: nature of injury in Part I or Part II of item 18.) Pt. fell on July 30th while walking on the ward and sustained a fractured right hip.	
20c. TIME OF INJURY Month, Day, Year 4-15 p. m. July 30 19 56		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville 28, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE George M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8-31-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-4-56	
22c. NAME OF CEMETERY OR CREMATORY McKindrie Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore (Harford Co)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 S. Paul Street		ADDRESS SEP 4 1956	
24a. REC'D BY REGISTRAR P. E. Harry		24b. REGISTRAR'S SIGNATURE	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
SEP 4 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08046

8074

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH o. COUNTY <i>N.H. Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>N.H. Balto.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparrows Point</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparrows Point</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>605 E St.</i>				d. STREET ADDRESS <i>605 E Street</i>			
3. NAME OF DECEASED (Type or print) First <i>CLARENCE</i> Middle <i>ALBERT</i> Last <i>PETERS</i>				4. DATE OF DEATH Month <i>Aug.</i> Day <i>12,</i> Year <i>1956</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 12, 1894</i>		9. AGE (In years last birthday) <i>61 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bricklayer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bethlehem Steel</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Mordecai T. Peters</i>				14. MOTHER'S MAIDEN NAME <i>Dora May Smith</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>World War 1 213-09-4057</i>		17. INFORMANT <i>Mrs. Mary A. Peters - 605 E St., Sparrows Pt.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Angiotrophic Latent Sclerosis</i> <i>356.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1, 1950</i> , to <i>Aug. 12, 1956</i> , that I last saw the deceased alive on <i>Aug. 12, 1956</i> , and that death occurred at <i>2:05 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>James T. Means</i>				ADDRESS (Street, city or town, state) DATE SIGNED <i>520 D. St. Balto. 1956 8/13/56</i>			
PHYSICIAN'S NAME (Type) <i>James T. Means</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/15/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Balto. Co., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Lickner</i>				ADDRESS <i>Louis. Balto.</i>		24a. REC'D BY REGISTRAR <i>Aug 14 1956</i>	
				24b. REGISTRAR'S SIGNATURE <i>James L. Lickner</i>			

MEDICAL CERTIFICATION

• 10 10 10

BUREAU V.

1956 15 506

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general officer, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8075

CERTIFICATE OF DEATH

08047

Reg. Dist. No.

40

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>		c. LENGTH OF STAY IN 1b <u>5 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9219 Belair Rd.</u>		d. STREET ADDRESS <u>9219 Belair Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Piotrowski</u> Last		4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 18, 1885</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	
13. FATHER'S NAME <u>Ludwig Rapert</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Lucille Wesolowski</u>		Address <u>9219 Belair Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>april 16</u> , 19 <u>50</u> , to <u>Aug 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 25</u> , 19 <u>56</u> , and that death occurred at <u>5:20 p.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>7122 Harford Rd Baltimore</u>	
PHYSICIAN'S NAME (Type) <u>DR JOS. SKLOVEN</u>		<u>14, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 30, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lisaku Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>Dr. Walter Hemmelt</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Walter Hemmelt</u>	
DATE <u>AUG 30 1956</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8076
CERTIFICATE OF DEATH

08048
Reg. Dist. No. 22

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Eccleston</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Eccleston</i>	
c. LENGTH OF STAY IN 1b <i>50 yrs +</i>		d. STREET ADDRESS <i>"The Branches"</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>The Branches</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ALICE DICKENSON PIPER</i>		4. DATE OF DEATH Month <i>Aug</i> Day <i>7</i> Year <i>1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 14 1874</i>
9. AGE (In years lost birthday) <i>81</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>7</i> Hours <i>7</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto., Co., Md</i>		12. CITIZEN OF WHAT COUNTRY <i>USA.</i>	
13. FATHER'S NAME <i>Charles H Pitts</i>		14. MOTHER'S MAIDEN NAME <i>Mary Bacot Person</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>James Piper Eccleston Balto Co</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Obesity - art. sclerosis - old age</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 5</i> , 195 <i>5</i> , to <i>Aug 7</i> , 195 <i>6</i> , that I last saw the deceased alive on <i>Aug 5</i> , 195 <i>5</i> , and that death occurred at <i>6 P</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1101 St Paul St 2</i> DATE SIGNED			
ACTUAL SIGNATURE <i>Walter A. Baetjer</i> M.D.		DATE SIGNED <i>Aug 10 1956</i>	
PHYSICIAN'S NAME (Type) <i>Walter A. Baetjer, M.D.</i>		24b. REGISTRAR'S SIGNATURE <i>Dorothy Murrell</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Aug 9 1956 St Thomas</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Garrison Balto Co Md.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins, Son Co 4905 York Rd</i>		24a. REC'D BY REGISTRAR <i>Aug 10 1956</i>	

BUREAU V. S.

AUG 10 1956

RECEIVED

8077

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>329 HILLEN RD</u>				d. STREET ADDRESS <u>329 HILLEN RD</u>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>PRATT</u> Last <u>PRATT</u>				4. DATE OF DEATH Month <u>AUG.</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNKNOWN</u>	9. AGE (In years last birthday) <u>80?</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>MARY PRATT 329 HILLEN RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 YR.</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>William A. Pilsbury</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>William A. Pilsbury</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
<u>burial</u>	<u>8/31/56</u>	<u>Pleasant Rest</u>		<u>Towson md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE		
<u>Am. L. Blatman</u>		<u>1701 Mc Culloch</u>		<u>AUG 29 1956</u>	<u>Mabel Mayo</u>		
		<u>Baltimore md.</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 17
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF MEDICAL EXAMINER		DATE		PLACE							

BUREAU Y. S.

AUG 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8078

CERTIFICATE OF DEATH

08050

Reg. Dist. No. 45

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLGATE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLGATE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7420 POPLAR AVE.		d. STREET ADDRESS 7420 POPLAR AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HARRY DRAPER PRESTON		4. DATE OF DEATH Month Day Year AUGUST 28, 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1884
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN RETIRED	
11. BIRTHPLACE (State or foreign country) HARFORD COUNTY MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM PRESTON		14. MOTHER'S MAIDEN NAME MARTHA DORSEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216 03 9238	
17. INFORMANT MRS MARY ALICE PRESTON		Address SAME.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Cerebral Thrombosis DUE TO arteriosclerosis - Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension and Heart Disease (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/10/56, 1956, to 8/28/56, 1956, that I last saw the deceased alive on 8/27/56, 1956, and that death occurred at M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles Beun M.D.		ADDRESS (Street, city or town, state) 7903 W. Woodrow St.	
DATE SIGNED 8/29/56			
PHYSICIAN'S NAME (Type) OSVALDO BEPRIOS MD		Balt. Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 31, 1956	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC. 1649 EAST NORTH AVE. BALTIMORE, MARYLAND.		24a. REC'D BY REGISTRAR SEP 4 1956	
24b. REGISTRAR'S SIGNATURE Edith Hurley			

BUREAU V. S.

SEP 4 1956

RECEIVED

7954

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4414 Linden Ave.		d. STREET ADDRESS 4414 Linden Ave.	
3. NAME OF DECEASED (Type or print) First Charles Middle Herman Last Proffen Sr.		4. DATE OF DEATH Month Aug. Day 26 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1890
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR: Months 66 Days 66 Hours 66 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cons. Engineer		10b. KIND OF BUSINESS OR INDUSTRY Steel Products	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? Md.	
13. FATHER'S NAME Ferdinand Proffen		14. MOTHER'S MAIDEN NAME Julia Prufer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. C.H. Proffen		Address 4414 Linden Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Carcinoma 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with metastasis to vertebrae DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 22, 1956 , to Aug 26, 1956 , that I last saw the deceased alive on Aug 26, 1956 , and that death occurred at 9 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.S. Parson		DATE SIGNED 1711 Selma Ave Balto 27th Aug 28-56	
PHYSICIAN'S NAME (Type) W.S. PARSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-30-56	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	22d. LOCATION (City, town, or county) (State) Pikesville Md.
23. FUNERAL DIRECTOR'S SIGNATURE Forley Funeral Home - Catonsville, Md.		24a. REC'D BY REGISTRAR SEP 4 1956	
24b. REGISTRAR'S SIGNATURE Dr. Leo M. Juffer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08052

8079

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE		STATE MD		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		LENGTH OF STAY (in this place) 9 years		CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		3 Vol-4	
TOWN				STREET ADDRESS (If rural give location) 3002 WAYNE AVE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MASONIC HOME							
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) ANNIE GRACE PUBLLOW				4. DATE OF DEATH (Month) (Day) (Year) AUG. 27 19 56			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH 7/6/1875	9. AGE last birthday 81 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN SHIPLEY				14. MOTHER'S MAIDEN NAME ANNIE R. PITT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS Frank Smith Jr. Cockeysville, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) Arterio Sclerotic						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO Cardio Vascular Disease						9 YEARS.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> el work <input type="checkbox"/> Not white <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 12/31 , 19 54 , to 8/27 , 19 56 , that I last saw the deceased alive on 8/24 , 19 56 , and that death occurred at 2:38 A.M. from the causes and on the date stated above.							
SIGNATURE Albion T. Kees				ADDRESS (Street, city, town, state) Cockeysville, Md.		DATE SIGNED 8/27/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 8.30.56		NAME OF CEMETERY OR CREMATORY Gooden PK		LOCATION (City, town, or county) (State) BALTO. MD	
24. REC'D BY REGISTRAR AUG 29 1956		REGISTRAR'S SIGNATURE Frank Smith Jr.		25. FUNERAL DIRECTOR'S SIGNATURE Wm Cook		ADDRESS 1417 St. Paul St.	

CERTIFICATE OF DEATH

Form No. 1

REGISTRATION DISTRICT OFFICIAL

DEATH

BALTIMORE

MARRIAGE NAME

DATE

ANNIE GRACE PEBLOW

AGE

61

HOUSE

JOHN SHIPLEY

WIFE

REGISTRATION DISTRICT OFFICIAL

ANNIE GRACE PEBLOW

ANNIE GRACE PEBLOW

BUREAU Y. L.

AUG 29 1956

RECEIVED

1501 1st - K. 20 100000 1/2

AUG 28 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

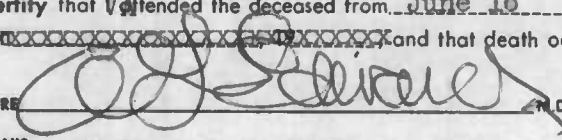
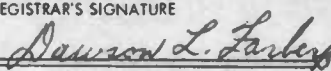
8080

CERTIFICATE OF DEATH

08053

44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 54 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2824 Parkwood Avenue			
3. NAME OF DECEASED (Type or print) First OLIVER Middle (NMI) Last PULLEY				4. DATE OF DEATH Month August Day 11 Year 1956			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/21/94		9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10b. KIND OF BUSINESS OR INDUSTRY Shipping Business		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Philip Pulley				14. MOTHER'S MAIDEN NAME Victoria Sleeper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Clin. Rec., Vet Adm. Hosp., Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE, PETECHIAL, GENERALIZED 204.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PAUCYTOPENIA DUE TO (c) MONOCYTIC LEUKEMIA ACUTE						INTERVAL BETWEEN ONSET AND DEATH 3 days 4 Weeks 5 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 18 , 19 56 , to August 11 , 19 56 , and that death occurred at 5:25 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE 				ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland			
PHYSICIAN'S NAME (Type) ARTHUR G. EDWARDS, M. D.				DATE SIGNED 8/12/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-15-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Holland's Funeral Home, 1631 Druid Hill Ave.				24a. REC'D BY REGISTRAR AUG 14 1956		24b. REGISTRAR'S SIGNATURE 	
ADDRESS Baltimore, Maryland							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AUG 14 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

Item 9 Filed 203 9-11-56 et
8081
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 156 Orville Road				d. STREET ADDRESS 156 Orville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle E. Last Pyne Jr.				4. DATE OF DEATH Month August Day 31 Year 1956			
5. SEX M	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1901		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Welsh Const. Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E. Pyne				14. MOTHER'S MAIDEN NAME Mary ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-05-0195		17. INFORMANT Address Charles E. Pyne, 156 Orville Rd. (Son)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 10 min							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Sept. 4, 1956		22c. NAME OF CEMETERY OR CREMATORY Moreland Memoria 1 Cem.	
22d. LOCATION (City, town, or county) (State) Baltimore County, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Homes 4210m Belair Rd.				24a. REC'D BY REGISTRAR SEP 4 1956		24b. REGISTRAR'S SIGNATURE Edith Hurley	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08055
44

8082

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 5 1/2 Hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50 Veterans Administration Hospital				d. STREET ADDRESS 1407 Eutaw Place			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle C. Last RAFFERTY				4. DATE OF DEATH Month August Day 29 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 27, 1897	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min.		IF UNDER 24 HRS. Months 59 Days 59 Hours 59 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Production Manager				10b. KIND OF BUSINESS OR INDUSTRY Advertising Business New York, New York			
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME William C. Rafferty				14. MOTHER'S MAIDEN NAME Julia Kilpatrick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I 212-16-9406		17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH 420.1 DUE TO OLD POSTERIOR MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1:35 PM	
20f. (City or town) 6:05 PM				20g. (County) VAH, FORT HOWARD, MARYLAND		20h. (State) 8/30/56	
21. I certify that I attended the deceased from August 29, 1956 , to August 29, 1956 and that death occurred at 6:06 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 8/30/56							
ACTUAL SIGNATURE <i>George Lerner</i>				PHYSICIAN'S NAME (Type) GEORGE LERNER, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8/31/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National	
22d. LOCATION (City, town, or county) Baltimore, Maryland				22e. REC'D BY REGISTRAR SEP 6 1956		24b. REGISTRAR'S SIGNATURE <i>Lawson L. Lerner</i>	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.				ADDRESS 6009 Harford Road, Baltimore 14, Md.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF CLERK		17. SIGNATURE OF CHIEF OF BUREAU		18. SIGNATURE OF ASSISTANT CHIEF OF BUREAU		19. SIGNATURE OF DEPUTY CHIEF OF BUREAU		20. SIGNATURE OF SECRETARY	

BUREAU V. 2

SEP 6 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8983

CERTIFICATE OF DEATH

08056

Reg. Dist. No. 387

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cockeysville</u> LENGTH OF STAY (In this place) <u>life</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Powers Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cockeysville</u> STREET ADDRESS (If rural give location) <u>Powers Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>William Montgomery Randolph</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 26</u> 19 <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucas</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 6, 1905</u>
9. AGE last birthday <u>51</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cleaning</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>house-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Randolph</u>		14. MOTHER'S MAIDEN NAME <u>Georgiana Payne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT & ADDRESS <u>wife - Doris - Cockeysville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8:30 p.m.</u> , 19 <u>56</u> , to <u>Aug 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 26</u> , 19 <u>56</u> , and that death occurred at <u>8:30 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Elizabeth B. Starnell</u> M.D.		ADDRESS (Street, city, town, state) <u>Cockeysville, Md.</u> DATE SIGNED <u>8/26/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>8/30/56</u>	NAME OF CEMETERY OR CREMATORY <u>Basil Methodist Cem.</u>	LOCATION (City, town, or county) (State) <u>Cockeysville, Md.</u>
24. REC'D BY REGISTRAR <u>8/30/56</u>	REGISTRAR'S SIGNATURE <u>Anne A. MacRae</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Chetman Jr.</u>	ADDRESS <u>101 Mt. Culler St. Baltimore</u>

CERTIFICATE OF DEATH

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

1956

AMOUNT PAID

DATE OF BIRTH AND PLACE OF BIRTH

1956

BUREAU V. S.

AUG 28 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8084 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

0805744

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEN GIES		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEN GIES			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle REGISTER Last				4. DATE OF DEATH Month August Day 23 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 18, 1910	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT George Register		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic cardiovascular disease (c) Arteriosclerotic cardiovascular disease DUE TO (a) stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. Fisher				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/24/56	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-30-56		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly				ADDRESS Essex Md		24a. REG'D BY REGISTRAR AUG 30 1956	
						24b. REGISTRAR'S SIGNATURE Lawson L. Fisher	

STATE OF NEW YORK DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH	
PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY		PATHOLOGICAL FINDINGS		LABORATORY FINDINGS	
SIGNATURE OF EXAMINER		DATE		PLACE							

BUREAU V. S.

AUG 30 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08058

8085 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> <u>Catonsville</u> <u>Betho</u> <u>MD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u> <u>28th</u>	c. LENGTH OF STAY IN 1b <u>20 months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>16-15-56</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hosp.</u>		e. STREET ADDRESS <u>920 Sheridan</u> <u>Chillum</u> <u>Terrace</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Burhett</u> Middle <u>Baltimore</u> Last <u>Reilly</u>	4. DATE OF DEATH Month <u>8</u> Day <u>11</u> Year <u>1956</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-2-1874</u> <u>82</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Wash D.C.</u>
13. FATHER'S NAME <u>Samuel Reilly</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Records S G S H</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio-Vascular</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Dissect</u> DUE TO (b) <u>Fracture Hip Rt.</u> DUE TO (c) <u>Divertericulosis & Diverticulitis with</u> <u>intestinal obstruction. Chronic Brain Syndrome</u> <u>ref + Hemiparesis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>May 18/1956</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Tripped over chair and fell</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>Aug 10 1956</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hosp</u>	20f. (City or town) (County) (State) <u>Catonsville</u> <u>28th</u> <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W. E. Mc G-eth</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. E. Mc G-eth</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 15, 1956</u>	22c. NAME OF CEMETERY, OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Geo. Co.</u> <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		24b. REGISTRAR'S SIGNATURE <u>F. E. Harry</u>	
ADDRESS <u>254 Carroll St.</u>		DATE <u>AUG 14 1956</u>	

14

1

03

2

BP

Case No. 1115
Name of Deceased: [illegible]
Age: 24
Sex: Male
Date of Death: 2-2-1956
Place of Death: [illegible]
Cause of Death: [illegible]
Manner of Death: [illegible]
Signature of Medical Examiner: [illegible]
Signature of Coroner: [illegible]

RECEIVED
AUG 14 1956
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8086 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **44** **08059**

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 41 DENTON AVE				d. STREET ADDRESS 41 DENTON AVE			
3. NAME OF DECEASED (Type or print) First MAMIE Middle REITZ Last REITZ				4. DATE OF DEATH Month AUGUST Day 24 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 24, 1889	9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 6 Days 7 Hours 0 Min. 0		11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN WISSNER				14. MOTHER'S MAIDEN NAME MARY KOHLEPP			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT Address MRS CHARLOTTE HINKELMAN 412 DENTON			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Heart					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year 1956	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) BALTIMORE MARYLAND		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M.B. Davis M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) M.B. Davis M.D.		DATE SIGNED 8/25/56					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG 27, 1956		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN		22d. LOCATION (City, town, or county) (State) COLGATE MD	
23. FUNERAL DIRECTOR'S SIGNATURE ULLRICH FUNERAL HOME				ADDRESS 212 DUNDALK		24a. REC'D BY REGISTRAR DATE 8/28/56	
				24b. REGISTRAR'S SIGNATURE Dr. Dawson J. Farber			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

DEPARTMENT OF HEALTH - BALTIMORE 15
 DEPARTMENT OF HEALTH - BALTIMORE 15
 DEPARTMENT OF HEALTH - BALTIMORE 15

BUREAU V. 31

JUN 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08060

8087

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 38yrs4mt20dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Della Middle Rickard Last Rickard				4. DATE OF DEATH Month Aug. Day 12, Year 1956			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles Marley				14. MOTHER'S MAIDEN NAME Mattie Ridinger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records; SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) ---							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 7, 1956 , to Aug. 12, 1956 , that I last saw the deceased alive on Aug. 12, 1956 , and that death occurred at 9:10a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachler				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 8-14-56			
PHYSICIAN'S NAME (Type) Stella Wachler, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF ---		22c. NAME OF CEMETERY OR CREMATORY U. of M., Baltimore		22d. LOCATION (City, town, or county) (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ---				24a. REC'D BY REGISTRAR DATE ---		24b. REGISTRAR'S SIGNATURE Victor Harry	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. PLACE OF BIRTH [REDACTED]	
3. SEX [REDACTED]		4. AGE [REDACTED]	
5. OCCUPATION [REDACTED]		6. CAUSE OF DEATH [REDACTED]	
7. DATE OF DEATH [REDACTED]		8. PLACE OF DEATH [REDACTED]	
9. SIGNATURE OF PHYSICIAN [REDACTED]		10. SIGNATURE OF REGISTRAR [REDACTED]	
11. SIGNATURE OF WITNESS [REDACTED]		12. SIGNATURE OF WITNESS [REDACTED]	
13. SIGNATURE OF WITNESS [REDACTED]		14. SIGNATURE OF WITNESS [REDACTED]	
15. SIGNATURE OF WITNESS [REDACTED]		16. SIGNATURE OF WITNESS [REDACTED]	
17. SIGNATURE OF WITNESS [REDACTED]		18. SIGNATURE OF WITNESS [REDACTED]	
19. SIGNATURE OF WITNESS [REDACTED]		20. SIGNATURE OF WITNESS [REDACTED]	
21. SIGNATURE OF WITNESS [REDACTED]		22. SIGNATURE OF WITNESS [REDACTED]	
23. SIGNATURE OF WITNESS [REDACTED]		24. SIGNATURE OF WITNESS [REDACTED]	
25. SIGNATURE OF WITNESS [REDACTED]		26. SIGNATURE OF WITNESS [REDACTED]	
27. SIGNATURE OF WITNESS [REDACTED]		28. SIGNATURE OF WITNESS [REDACTED]	
29. SIGNATURE OF WITNESS [REDACTED]		30. SIGNATURE OF WITNESS [REDACTED]	
31. SIGNATURE OF WITNESS [REDACTED]		32. SIGNATURE OF WITNESS [REDACTED]	
33. SIGNATURE OF WITNESS [REDACTED]		34. SIGNATURE OF WITNESS [REDACTED]	
35. SIGNATURE OF WITNESS [REDACTED]		36. SIGNATURE OF WITNESS [REDACTED]	
37. SIGNATURE OF WITNESS [REDACTED]		38. SIGNATURE OF WITNESS [REDACTED]	
39. SIGNATURE OF WITNESS [REDACTED]		40. SIGNATURE OF WITNESS [REDACTED]	
41. SIGNATURE OF WITNESS [REDACTED]		42. SIGNATURE OF WITNESS [REDACTED]	
43. SIGNATURE OF WITNESS [REDACTED]		44. SIGNATURE OF WITNESS [REDACTED]	
45. SIGNATURE OF WITNESS [REDACTED]		46. SIGNATURE OF WITNESS [REDACTED]	
47. SIGNATURE OF WITNESS [REDACTED]		48. SIGNATURE OF WITNESS [REDACTED]	
49. SIGNATURE OF WITNESS [REDACTED]		50. SIGNATURE OF WITNESS [REDACTED]	
51. SIGNATURE OF WITNESS [REDACTED]		52. SIGNATURE OF WITNESS [REDACTED]	
53. SIGNATURE OF WITNESS [REDACTED]		54. SIGNATURE OF WITNESS [REDACTED]	
55. SIGNATURE OF WITNESS [REDACTED]		56. SIGNATURE OF WITNESS [REDACTED]	
57. SIGNATURE OF WITNESS [REDACTED]		58. SIGNATURE OF WITNESS [REDACTED]	
59. SIGNATURE OF WITNESS [REDACTED]		60. SIGNATURE OF WITNESS [REDACTED]	
61. SIGNATURE OF WITNESS [REDACTED]		62. SIGNATURE OF WITNESS [REDACTED]	
63. SIGNATURE OF WITNESS [REDACTED]		64. SIGNATURE OF WITNESS [REDACTED]	
65. SIGNATURE OF WITNESS [REDACTED]		66. SIGNATURE OF WITNESS [REDACTED]	
67. SIGNATURE OF WITNESS [REDACTED]		68. SIGNATURE OF WITNESS [REDACTED]	
69. SIGNATURE OF WITNESS [REDACTED]		70. SIGNATURE OF WITNESS [REDACTED]	
71. SIGNATURE OF WITNESS [REDACTED]		72. SIGNATURE OF WITNESS [REDACTED]	
73. SIGNATURE OF WITNESS [REDACTED]		74. SIGNATURE OF WITNESS [REDACTED]	
75. SIGNATURE OF WITNESS [REDACTED]		76. SIGNATURE OF WITNESS [REDACTED]	
77. SIGNATURE OF WITNESS [REDACTED]		78. SIGNATURE OF WITNESS [REDACTED]	
79. SIGNATURE OF WITNESS [REDACTED]		80. SIGNATURE OF WITNESS [REDACTED]	
81. SIGNATURE OF WITNESS [REDACTED]		82. SIGNATURE OF WITNESS [REDACTED]	
83. SIGNATURE OF WITNESS [REDACTED]		84. SIGNATURE OF WITNESS [REDACTED]	
85. SIGNATURE OF WITNESS [REDACTED]		86. SIGNATURE OF WITNESS [REDACTED]	
87. SIGNATURE OF WITNESS [REDACTED]		88. SIGNATURE OF WITNESS [REDACTED]	
89. SIGNATURE OF WITNESS [REDACTED]		90. SIGNATURE OF WITNESS [REDACTED]	
91. SIGNATURE OF WITNESS [REDACTED]		92. SIGNATURE OF WITNESS [REDACTED]	
93. SIGNATURE OF WITNESS [REDACTED]		94. SIGNATURE OF WITNESS [REDACTED]	
95. SIGNATURE OF WITNESS [REDACTED]		96. SIGNATURE OF WITNESS [REDACTED]	
97. SIGNATURE OF WITNESS [REDACTED]		98. SIGNATURE OF WITNESS [REDACTED]	
99. SIGNATURE OF WITNESS [REDACTED]		100. SIGNATURE OF WITNESS [REDACTED]	

BUREAU V. 21

JUN 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8048 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08061
43

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Baltimore b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Essex - 21		c. LENGTH OF STAY IN 1b 11 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex - 21			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1621 Gale Road				d. STREET ADDRESS 1621 Gale Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DELMER Middle LAWRENCE Last ROARK				4. DATE OF DEATH Month August Day 26 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1923		9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR Months 33 Days 33	IF UNDER 24 HRS. Hours 33 Min. 33
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Ruberoid Co.		11. BIRTHPLACE (State or foreign country) Bristol, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Kelly Roark				14. MOTHER'S MAIDEN NAME Cordie Rogers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> World War II		16. SOCIAL SECURITY NO. 415-40-9040		17. INFORMANT Everett Roark Address 1207 Goff St. Bristol, Tenn.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left hemothorax secondary to traumatic rupture of aorta DUE TO 816X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH _____
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver - struck by another auto					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8/26 1956 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Baltimore (County) _____ (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Paul F. Guerin				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin				DATE SIGNED 8/27/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 30, 1956		22c. NAME OF CEMETERY OR CREMATORY Balto. National		22d. LOCATION (City, town, or county) Baltimore, Md. (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE 401 S. Chester St. #31				24a. REC'D BY REGISTRAR Aug 29 1956		24b. REGISTRAR'S SIGNATURE Edith Huley	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8988

CERTIFICATE OF DEATH

08062 31

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - ROCKDALE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ROCKDALE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3214 MAYFIELD AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LODA Middle ERMA Last ROGERS		4. DATE OF DEATH Month 8 Day 13 Year 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 6, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	9. AGE (In years, last birthday) 66 yrs.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM T. GOSSAGE		14. MOTHER'S MAIDEN NAME MINNIE PINKNEY PRICE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. none	
17. INFORMANT DAUGHTER - MRS. OGLE		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 DAYS 20 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from MARCH 12, 1952 to AUGUST 13, 1956 , that I last saw the deceased alive on AUGUST 13, 1956 , and that death occurred at 4:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edwin L. Pierpont		ADDRESS (Street, city or town, state) DATE SIGNED 8204 LIBERTY RD., BALTO. MD.	
PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/15/56	22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cem.	22d. LOCATION (City, town, or county) (State) Randallstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons		24a. REC'D BY REGISTRAR AUG 14 1956	
ADDRESS 17, Md.		24b. REGISTRAR'S SIGNATURE Dr. Wm. E. Martin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED WILLIAM T. ...</p>		<p>DATE OF DEATH AUG 15 1956</p>	
<p>AGE 44</p>		<p>SEX M</p>	
<p>PLACE OF BIRTH ...</p>		<p>DATE OF BIRTH ...</p>	
<p>CAUSE OF DEATH ...</p>		<p>PLACE OF DEATH ...</p>	
<p>DATE OF DEATH AUG 15 1956</p>		<p>TIME OF DEATH ...</p>	
<p>NAME OF PHYSICIAN ...</p>		<p>NAME OF FUNERAL HOME ...</p>	
<p>NAME OF NEXT OF KIN ...</p>		<p>NAME OF BURIAL PLACE ...</p>	
<p>NAME OF COUNTY OF DEATH ...</p>		<p>NAME OF STATE OF DEATH ...</p>	

RECEIVED
 AUG 15 1956
 BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 08063											
1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i> <i>MILLERS ISLAND</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTIMORE</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTIMORE</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <i>405 S. REGISTER ST.</i>						
3. NAME OF DECEASED (Type or print) <i>FRANCES J.</i> First <i>ROSSO</i> Middle Last					4. DATE OF DEATH <i>AUG 29</i> Month <i>1956</i> Day Year						
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>APRIL 6, 1942</i>		9. AGE (In years last birthday) <i>14</i> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>VINCENT M ROSSO</i>					14. MOTHER'S MAIDEN NAME <i>FRANCES WOUTYSIAK</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>FRANCES WOUTYSIAK</i> Address <i>405 REGISTER ST.</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>DROWNING</i> <i>929.8</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>WAS SWIMMING & STEPPED IN HOLE</i>								
20c. TIME OF INJURY Month, Day, Year <i>25</i> <i>8-28</i> <i>56</i> a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Off. MILLERS ISL.</i>		20f. (City or town) (County) (State) <i>NR Sp. Pt. - 19 BALTO MD</i>				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>M. B. Davis</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <i>M. B. DAVIS M.D.</i>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			22b. DATE THEREOF <i>9/3/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>HOLY ROSARY CEM. GERMAN HILL RD. DUNDALK</i>			22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Weber</i>					ADDRESS <i>401 S. Chester St.</i>		24a. REC'D BY REGISTRAR <i>Edith Hurley</i>		24b. REGISTRAR'S SIGNATURE <i>Edith Hurley</i>		
DATE <i>SEP 4 1956</i>											

15
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15

RECEIVED
 SEP 4 1956
 BUREAU V. 3

[The following text is mirrored bleed-through from the reverse side of the document and is not legible.]

NAME OF DECEASED: _____
 SEX: _____ AGE: _____
 DATE OF DEATH: _____
 PLACE OF DEATH: _____
 CAUSE OF DEATH: _____
 MANNER OF DEATH: _____
 SIGNATURE OF EXAMINER: _____
 OFFICE OF THE MEDICAL EXAMINER: _____

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3 Mo. 28 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input type="checkbox"/> YES			
3. NAME OF DECEASED (Type or print) First Nathan Middle Rothenberg Last Rothenberg				4. DATE OF DEATH Month August Day 29 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-90	9. AGE (In years last birthday) yrs. 65 66	IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce Man
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hyman Rothenberg				14. MOTHER'S MAIDEN NAME Fannie Epstein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records of Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial scarring due to old systemic and septal myocardial infarction (c) due to coronary arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH years months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 1, 19 56 , to Aug. 29, 19 56 , that I last saw the deceased alive on Aug. 29, 19 56 , and that death occurred at 2:30 p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ellis S. Margolin M.D.				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL 8-30-56			
DATE SIGNED							
PHYSICIAN'S NAME (Type) Ellis S. Margolin, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/1/1956		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. E. Smith				24a. REC'D BY REGISTRAR DATE 31 1956		24b. REGISTRAR'S SIGNATURE F. E. Barry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
M. J. J. J.		45		M		W		1911		BALTIMORE		BALTIMORE		U.S.A.	
MIDDLE NAME		LAST NAME		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER	
J. J.		J. J.		M		W		W		W		W		W	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		CITY OF BURIAL		COUNTRY OF BURIAL	
1956		BALTIMORE		BALTIMORE		U.S.A.		1956		BALTIMORE		BALTIMORE		U.S.A.	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		POLITICAL PARTY		MILITARY SERVICE		OTHER	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		CATHOLIC		DEMOCRAT		U.S. ARMY		NONE	
DATE OF REPORT		PLACE OF REPORT		CITY OF REPORT		COUNTRY OF REPORT		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		COUNTRY OF SIGNATURE	
1956		BALTIMORE		BALTIMORE		U.S.A.		1956		BALTIMORE		BALTIMORE		U.S.A.	

BUREAU V. 3

AUG 31 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
8991 8/24/56 Item 5, Film G 201									
CERTIFICATE OF DEATH									
Reg. Dist. No. 08065									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 48 Dunvegan Rd					d. STREET ADDRESS 48 Dunvegan Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Henry Rottloff			First Middle Last		4. DATE OF DEATH Aug. 5/56		Month Day Year 19		
5. SEX Female		6. COLOR OR RACE White		7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 6, 1901		9. AGE (In years last birthday) 55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY Isthmian Shipping Co.		11. BIRTHPLACE (State or foreign country) Balto. Md.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Adolf Rottloff					14. MOTHER'S MAIDEN NAME Pauline Englehardt				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 341 01 0474		17. INFORMANT Mrs. Phyllis H. Rottloff			
						Address 48 Dunvegan Rd, Catonsville 28, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYOCARDITIS (ARTERIOSCLEROSIS) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS. ARTERIAL DUE TO (c) HYPERTENSION. INTERVAL BETWEEN ONSET AND DEATH 5 YEARS									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Aug. 4, 1956 to Aug. 5, 1956 ; that I last saw the deceased alive on Aug. 4, 1956 , and that death occurred at 12:30 A.M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE S. Lloyd Johnson					ADDRESS (Street, city or town, state) Catonsville Md.				
PHYSICIAN'S NAME (Type) S. LLOYD JOHNSON, M.D.					DATE SIGNED Aug. 8, 1956				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 8/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National			22d. LOCATION (City, town, or county) (State) Baltimore, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. W. [Signature]					ADDRESS 4101 Edmondson Ave		24a. REC'D BY REGISTRAR AUG 8 1956		24b. REGISTRAR'S SIGNATURE V. E. Harvey

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. WHITE		AUG 8 1956	
AGE		SEX	
65		M	
MARRIED		OCCUPATION	
YES		RETIRED	
PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE, MD		BALTIMORE, MD	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
IMMEDIATE CAUSE		INTERMEDIATE CAUSE	
CORONARY THROMBOSIS		HYPERTENSION	
PREVIOUS ILLNESS		PREVIOUS SURGERY	
NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. WHITE		J. H. WHITE	
DATE		DATE	
AUG 8 1956		AUG 8 1956	

BUREAU V. S.

AUG 8 1956

RECEIVED

James H. White

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08066

8092

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 16 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 328 Marydel Road			
3. NAME OF DECEASED (Type or print) First WARNER Middle (NMI) Last SCARBORO				4. DATE OF DEATH Month August Day 18 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/10/80	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75		IF UNDER 24 HRS. Days 18 Hours 19 Min. 56			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Loudon Park Cemetery		11. BIRTHPLACE (State or foreign country) Harford Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Scarboro				14. MOTHER'S MAIDEN NAME Annie Scarboro			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-09-4455		17. INFORMANT CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA BILATERAL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 491X DUE TO (c) Coronary Arteriosclerotic heart disease. Calcific Disease of Aorta. Pulmonary infarct Left Lower Lobe.				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Arteriosclerotic heart disease. Calcific Disease of Aorta. Pulmonary infarct Left Lower Lobe.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 2 , 19 56 , to August 18 , 19 56 . and that death occurred on August 18, 1956 , and that death occurred at 11:47 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE George Leuner M.D.				ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland			
DATE SIGNED Aug 22, 1956							
PHYSICIAN'S NAME (Type) GEORGE LEUNER, M. D.				ADDRESS VAH, Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 22, 1956		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Ave. Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James Schuch ADDRESS 3512 Frederick Ave. Baltimore, Maryland				24. REC'D BY REGISTRAR Aug 22, 1956 REGISTRAR'S SIGNATURE Dawson L. Garber			

CERTIFICATE OF DEATH

Form with fields for Name, Sex, Age, Date of Birth, Place of Birth, Date of Death, Cause of Death, and other medical details. The text is mirrored and difficult to read.

BUREAU V. S.

AUG 22 1956

RECEIVED

MEDICAL CERTIFICATION

VS A1S (4)
ISM 9/SS

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

BUREAU V. 5

JUG 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08068

Reg. Dist. No. 45

8094

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home				d. STREET ADDRESS 307 George Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Frederick Middle Walter Last Schenning				4. DATE OF DEATH Month Aug Day 24th Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8th, 1936		9. AGE (In years last birthday) 20 yrs.	IF UNDER 1 YEAR Months 20 Days 24 Hours 19	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry John Schenning				14. MOTHER'S MAIDEN NAME Anna Pietruska			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Parents		Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 353.3 Epilepsy DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 18 days							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Aug 24 , 19 56 , to Aug 24 , 19 56 , that I last saw the deceased alive on Aug 24 , 19 56 , and that death occurred at 2:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James F. White				ADDRESS (Street, city or town, state) 422 Eastern Ave. Baltimore, Md.			
PHYSICIAN'S NAME (Type) James F. White				DATE SIGNED 8/25/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug, 27, 56.		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary		22d. LOCATION (City, town, or county) (State) German Hill Rd. Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly				ADDRESS 418 Eastern Blvd. Essex		24a. REC'D BY REGISTRAR 8/28/56	
				24b. REGISTRAR'S SIGNATURE Edith Hurley			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
8995 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

08069 37
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 39 Oakway Road		d. STREET ADDRESS 39 Oakway Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHESTER WILLIAM SCHERF		4. DATE OF DEATH Month August Day 6 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1893
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Senior Clerk		10b. KIND OF BUSINESS OR INDUSTRY B & D Mfg. Co.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles F. Scherf		14. MOTHER'S MAIDEN NAME Delia O'Laughlin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. Family records	
17. INFORMANT Family records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 WKS. 5 YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN. , 19 55 , to AUG. 6 , 19 56 , that I last saw the deceased alive on AUG. 3 , 19 56 , and that death occurred at 6:20 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Pillsbury		ADDRESS (Street, city or town, state) Timonium, Md	
DATE SIGNED 8/6/56			
PHYSICIAN'S NAME (Type) WILLIAM A. PILLSBURY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 9, 1956	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Parkville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons		ADDRESS Towson, Md.	
24a. REC'D BY REGISTRAR Aug 10 1956		24b. REGISTRAR'S SIGNATURE Anne Mas R...	

BU

AUG 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8096
CERTIFICATE OF DEATH

08070
40

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9415 Belair Rd.</u>		d. STREET ADDRESS <u>9415 Belair Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>B.</u> Last <u>Schone</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1891</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>J. Harman Schone</u>		14. MOTHER'S MAIDEN NAME <u>Louise Hofstetter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-32-0900</u>	
17. INFORMANT <u>Mrs. Elva A. Schone</u>		Address <u>9415 Belair Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary occlusion and infarction</u> DUE TO (c) <u>1 month</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 13, 1956</u> , to <u>Aug. 8, 1956</u> , that I last saw the deceased alive on <u>Aug. 4, 1956</u> , and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>Aug. 9, 1956</u>	
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 11, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassola Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>AUG 13 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Walter Hammett</u>	

CERTIFICATE OF DEATH

DATE OF DEATH 1966 AUG 13		PLACE OF DEATH HOME	
TIME OF DEATH 10:00 AM		AGE 78	
SEX F		RACE W	
MARITAL STATUS MARRIED		OCCUPATION RETIRED	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
PLACE OF BIRTH BALTIMORE, MD		DATE OF BIRTH 1900	
NAME OF DECEASED MARY ANN SMITH		NAME OF NEXT OF KIN JOHN SMITH	
ADDRESS OF DECEASED 1234 MAIN ST, BALTIMORE, MD		ADDRESS OF NEXT OF KIN 5678 MAIN ST, BALTIMORE, MD	
SIGNATURE OF DECEASED (None)		SIGNATURE OF NEXT OF KIN (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

BUREAU V. 8

1966 AUG 13

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8097

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural near Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural near Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Villa Maria</u>		d. STREET ADDRESS <u>Glenarm Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Sister Mary Mechtilde Schroen</u>		4. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 8, 1868</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Schroen</u>		14. MOTHER'S MAIDEN NAME <u>Elisabeth Wagner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Sr. Mary Clara Notch Cliff, Md.</u>		Address <u> </u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio, vascular, renal, arterio sclerotic disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 mo.</u> <u>12 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u> </u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		
21. I certify that I attended the deceased from <u>May 20</u> , 19 <u>52</u> , to <u>Aug. 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug. 7</u> , 19 <u>56</u> , and that death occurred at <u>3:45</u> A.M., from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell, M.D. 7501 Yotk Road, Towson, Md.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-28-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM. NOTCH CLIFF NR TOWSON, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Feiler</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>8/25/56</u>
24b. REGISTRAR'S SIGNATURE <u> </u>		

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-35 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8098

CERTIFICATE OF DEATH

08072

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>BALTO.</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ARMACOST NURSING HOME</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>L</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTO.</u> 3V01-4 STREET ADDRESS (If rural give location) <u>5607 BIRCHWOOD AVE.</u>	
3. NAME OF DECEASED (Type or Print) <u>FANNIE A. SCOGGINS</u> (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>8</u> <u>22</u> 19 <u>56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>12/31/1883</u>
9. AGE last birthday <u>72</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) 11. IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>RANDOLPH BOYER</u>		14. MOTHER'S MAIDEN NAME <u>JULIE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS <u>MADELINE GEHRMANN CLINTON</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) <u>Interdependent Cardio-vascular Disease</u> ANTECEDENT CAUSE(S) (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) STATING UNDERLYING CAUSE LAST.		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Broncho pneumonia</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug 15, 1956</u> , to <u>8-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-22</u> , 19 <u>56</u> , and that death occurred at <u>1:25 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>A. J. Johnson</u> M.D.		ADDRESS (Street, city, town, state) <u>3101 N. Charles St</u>	
DATE SIGNED <u>8-23-56</u>		23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	
DATE THEREOF <u>8/25/56</u>		NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER CENT. BALTO.</u>	
LOCATION (City, town, or county) <u>MD.</u>		24. REC'D BY REGISTRAR <u>MADELINE GEHRMANN</u>	
REGISTRAR'S SIGNATURE <u>Mabel Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. F. Hoffmann</u>	
ADDRESS <u>2219 LAKE AVE.</u>		DATE <u>AUG 24 1956</u>	

BUREAU V. S.

AUG 24 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sally Middle S. Last Scott				4. DATE OF DEATH Month August Day 3 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1870		9. AGE (In years last birthday) yrs. 86	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical Work		10b. KIND OF BUSINESS OR INDUSTRY Harford Cleaners		11. BIRTHPLACE (State or foreign country) King George, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Silas Somers				14. MOTHER'S MAIDEN NAME Liza Travers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-18-3736		17. INFORMANT Robert L. Badart Address 3911 Rokeby Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Cardio-Vascular disease 492.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1st, 1956 to Aug 3, 1956 , that I last saw the deceased alive on Aug 2, 1956 , and that death occurred at 9:41 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George A. Knipp M.D.				ADDRESS (Street, city or town, state) 4116 Edmondson Ave Baltimore Md DATE SIGNED Aug 4 1956			
PHYSICIAN'S NAME (Type) George A. Knipp M.D.				Baltimore 29 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-6-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc.				ADDRESS 1217 St. Paul Street		24a. REC'D BY REGISTRAR Aug 6 1956	
				24b. REGISTRAR'S SIGNATURE V.E. Harvey			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Name of Deceased		Date of Death	
Robert L. Robert		June 11, 1956	
Place of Birth		Place of Death	
Baltimore, Maryland		Baltimore, Maryland	
Age at Death		Sex	
65 years		Male	
Cause of Death		Manner of Death	
Heart Disease		Natural	
Immediate Cause		Underlying Cause	
Myocardial Infarction		Coronary Atherosclerosis	
Contributing Cause		Hypertension	
Date of Report		Signature of Registrar	
June 12, 1956		[Signature]	

BUREAU V. 3

JUN 7 1956

RECEIVED

BURIAL

JUN 7 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8100

CERTIFICATE OF DEATH

08074

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7900 Elmhurst Rd.</i>		d. STREET ADDRESS <i>7900 Elmhurst Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Mr. Oscar A. Shillingburg</i>		4. DATE OF DEATH <i>Aug. 17, 1956</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 20, 1880</i>
9. AGE (In years lost birthday) <i>76</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Pres. Md. Ship Ceiling Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Virginia</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Abraham Shillingburg</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Huttie</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Katherine Shillingburg</i>		Address <i>7900 Elmhurst Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Probable Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Myocardial degeneration, hypertensive induced by ingestion of 3 Daps. Tablets</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 9, 1956</i> to <i>Aug. 17, 1956</i> , that I last saw the deceased alive on <i>Aug. 17, 1956</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G. M. Bacon</i>		M.D. <i>2810 Taylor Ave</i> DATE SIGNED <i>8/18/56</i>	
PHYSICIAN'S NAME (Type) <i>A. M. BACON</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/20/1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Park</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>8/18/56</i>		24b. REGISTRAR'S SIGNATURE <i>G. M. Bacon</i>	

RECEIVED

BUREAU V. 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8101

CERTIFICATE OF DEATH

Reg. Dist. No.

0807530

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELICOTT CITY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RODGEWAY NURSING HOME				d. STREET ADDRESS 179 MAIN ST			
3. NAME OF DECEASED (Type or print) SYDNEY TANE SHIPLEY				4. DATE OF DEATH AUG. 11 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 6, 1924	
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERICAL				10b. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) ELICOTT CITY MD	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME E. RICHARD SHIPLEY				14. MOTHER'S MAIDEN NAME EDNA NITZEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT REBECCA GARNER Address BALTIMORE MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Brain 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Leukemic Carcinoma of Rt Breast DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 year 5 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-10 , 19 56 , to 8-11 , 19 56 , that I last saw the deceased alive on 8-10 , 19 56 , and that death occurred at 7:25 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE George E. Burgtorf M.D.				DATE SIGNED 8-12-56			
PHYSICIAN'S NAME (Type) GEORGE E. BURGTORF				ADDRESS (Street, city or town, state) ELICOTT CITY MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-14-56		22c. NAME OF CEMETERY OR CREMATORY ST JOHNS		22d. LOCATION (City, town, or county) (State) ELICOTT CITY MD	
23. FUNERAL DIRECTOR'S SIGNATURE E. C. HIGGINS ADDRESS BALTIMORE, ELICOTT CITY MD				24a. REC'D BY REGISTRAR DATE 14 1956		24b. REGISTRAR'S SIGNATURE V. E. Harvey	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED CARROLL, JAMES DATE OF BIRTH JAN 15 1895 PLACE OF BIRTH BALTIMORE, MD</p>		<p>DATE OF DEATH AUG 12 1956 PLACE OF DEATH BALTIMORE, MD</p>	
<p>RESIDENCE 123 MAIN ST BALTIMORE, MD</p>		<p>CAUSE OF DEATH HEART DISEASE ICD-9 CODE 410.9</p>	
<p>REPORTED BY JAMES CARROLL RELATIONSHIP SON</p>		<p>DATE OF REPORT AUG 14 1956 SIGNATURE JAMES CARROLL</p>	
<p>DATE OF INTERVIEW AUG 14 1956 INTERVIEWER J. CARROLL</p>		<p>DATE OF REVIEW AUG 14 1956 REVIEWER J. CARROLL</p>	

BUREAU V. 2

AUG 14 1956

RECEIVED

Item 2, Film 8102, 8/22/56 bh **CERTIFICATE OF DEATH**

Reg. Dist. No.

30

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			c. LENGTH OF STAY IN 1b <u>2 months</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wayne Convalescent Home</u>				d. STREET ADDRESS <u>6604 Murry Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>J.</u> Last <u>Shorty</u>				4. DATE OF DEATH Month <u>8</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13, 1874</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Standard Oil Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Unknown Shorty</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Mohr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Anna Milchling</u> Address <u>392 Evergreen Park Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma skin face Rt.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June 2, 1956</u> to <u>Aug 9, 1956</u> , that I last saw the deceased alive on <u>7 Aug 56</u> , and that death occurred at <u>1:45 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. F. McGloth</u> M.D.				ADDRESS (Street, city or town, state) <u>1707 Edmondson Ave</u> DATE SIGNED <u>8/9/56</u>			
PHYSICIAN'S NAME (Type) <u>W. F. McGloth</u>				<u>Catonsville 28nd</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Aug. 11, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>				ADDRESS <u>7401 Belair Rd</u>		24a. REC'D BY REGISTRAR <u>Aug 13 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>R. E. Harney</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

NAME OF DECEASED		DATE OF DEATH	
FREDERICK J. BROWN		AUG 13 1956	
AGE		SEX	
45		M	
RACE		RELIGION	
W		C	
BIRTHPLACE		PLACE OF BIRTH	
NEW YORK		NEW YORK	
MARRIAGE		EDUCATION	
M		H	
OCCUPATION		CAUSE OF DEATH	
C		H	
DISEASE		MANNER OF DEATH	
H		N	
DATE OF BURIAL		PLACE OF BURIAL	
AUG 15 1956		NEW YORK	
NAME OF FUNERAL HOME		NAME OF MINISTER	
J. B. BROWN		J. B. BROWN	
ADDRESS		CITY	
1234 5th Ave		NEW YORK	
STATE		COUNTY	
NY		NY	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF MINISTER		SIGNATURE OF REGISTRAR	

BUREAU V. S.

AUG 13 1956

RECEIVED

8103

MARYLAND STATE DEPARTMENT OF HEALTH

08077

Item 8: G201 8-20-56 L

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 32

2. DATE OF DEATH 8-11-56

1. NAME OF DECEASED
(Type or Print)

CHARLES SIMMS

3. PLACE OF DEATH:

Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland B. COUNTY BALTO.

8. FULL NAME OF HOSPITAL OR INSTITUTION

Rersterstown & Slade Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore BALTO Co.

D. STREET ADDRESS (If rural, give location)

2119 Llewellyn Ave.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

Dec. 21, 1920

9. AGE (In years last birthday)

35

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

St. Louis, MO.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Elizabeth ? (MN) Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Delores Simms 2119 Llewellyn Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MASSIVE HEMOPTYSIS
DUE TO RUPTURED AORTIC ANEURYSM

ANTECEDENT CAUSES

(B)

DUE TO

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY? YES ☒ NO ☐

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and found that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

23A. SIGNATURE

Paul K. Merriam M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED 8-12-56

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

Aug 13, 56

24C. NAME OF CEMETERY OR CREMATORY

Capters Cemetery

24D. LOCATION (City, town, or county)

Maple Grove, Va.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and leg

AL CERTIFICATION

RECEIVED
AUG 15 1956
BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8104

CERTIFICATE OF DEATH

08079

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7514 Marston Road</i>		d. STREET ADDRESS <i>2866 Lake Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs Jane E. Smith</i>		4. DATE OF DEATH <i>August 20th 1956</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 22, 1914</i>
9. AGE (In years last birthday) <i>42</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tailoring</i>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
13. FATHER'S NAME <i>Harry J. Craig</i>		14. MOTHER'S MAIDEN NAME <i>Phoebe Plain</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT <i>Mr. Samuel H. Smith, 2866 Lake Avenue</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of ascending colon with metastases to liver</i> DUE TO (b) <i>153X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug. 12, 1956</i> , to <i>Aug. 20, 1956</i> , that I last saw the deceased alive on <i>Aug. 20, 1956</i> , and that death occurred at <i>2 P.</i> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Marvin Goldstein</i> M.D.			
PHYSICIAN'S NAME (Type) <i>MARVIN GOLDSTEIN 5334 LIBERTY HEIGHTS AVE</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/23/1956</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR <i>AUG 21 1956</i> 24b. REGISTRAR'S SIGNATURE <i>Dr. Wm. E. Martin</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 173

AUG 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08080

8105

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 5426 Addington Rd.		d. STREET ADDRESS 5426 Addington Rd.	
3. NAME OF DECEASED (Type or print) First CHARLES Middle HARRY Last SMYRK		4. DATE OF DEATH Month Aug. Day 14, Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1871
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dispatcher		10b. KIND OF BUSINESS OR INDUSTRY Taxi	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Mawson J. Smyrk		14. MOTHER'S MAIDEN NAME Elizabeth Pasloe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. H. M. Smyrk - 3411 Milford Ave. Balto. 7, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Chronic Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) Senility		INTERVAL BETWEEN ONSET AND DEATH 4 yrs. 10 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1940 , to Aug 14, 1956 , that I last saw the deceased alive on Aug 12, 1956 , and that death occurred at 5:05 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Aug 15, 1956 DATE SIGNED			
ACTUAL SIGNATURE Dr. C. Wells M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/17/56	
22c. NAME OF CEMETERY OR CREMATORY Louisa Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto 17 Md		24a. REC'D BY REGISTRAR Aug. 17, 1956	
24b. REGISTRAR'S SIGNATURE F. E. Harry			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF RESIDENCE		COUNTY OF RESIDENCE		STATE OF RESIDENCE	
JAMES H. HARRIS		65		M		W		1891		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		TREATMENT		HISTORY OF PRESENT ILLNESS		HISTORY OF PREVIOUS ILLNESSES		HISTORY OF SURGERY		HISTORY OF DRUGS	
LABORER		8		M		C		HEART DISEASE		SUDDEN		2 WEEKS		NONE		NONE		NONE		NONE		NONE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF RESIDENCE		COUNTY OF RESIDENCE		STATE OF RESIDENCE		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH	
AUG 20 1956		10:00 AM		HOME		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU Y. H.

AUG 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08081

8047

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Welch, W. Va.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Welch</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Unknown</u>				d. STREET ADDRESS <u>Unknown</u>			
3. NAME OF DECEASED (Type or print) First <u>Buford</u> Middle <u>Edwin</u> Last <u>Sparks</u>				4. DATE OF DEATH Month <u>8</u> - Day <u>26</u> - Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-2-1922</u>	9. AGE (In years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ashland, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Greely Sparks</u>				14. MOTHER'S MAIDEN NAME <u>Ella Eans</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <u>Yes</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>O.G. Douglass Mortuary, Welch, W. Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>420.1</u> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Wm. H. Sparks</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-2-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Iaeger Memorial Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Roderfield, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donna D. J. Sparks</u>				ADDRESS <u>8410 7 WILKINSON</u>		24a. REC'D BY REGISTRAR <u>SEP 4 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

SEP 4 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8106 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

0808220

1. PLACE OF DEATH a. COUNTY Catonsville - Balto. Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 3210 Putty Hill Rd. - Balto. 14		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Zievuless Spear				4. DATE OF DEATH Month Day Year Aug. 7, 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown	
9. AGE (In years last birthday) 73 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? unknown	
13. FATHER'S NAME Antonio Zievuless				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) —		17. INFORMANT Address Records: Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia (Diagnosed 1926)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE J. E. McGrath				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) W. E. McGrath				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 7 Aug 56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-11-56		22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Taylorsville	
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Chmura				ADDRESS 1547 Chestnut St.		24a. REC'D BY REGISTRAR AUG 9 1956	
						24b. REGISTRAR'S SIGNATURE T. E. Harry	

AUG 10 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08083

44

8107

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 19 Days		d. STREET ADDRESS 3017 W. Lanvale Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle N. Last SPELLER		4. DATE OF DEATH Month August Day 2 Year 19 56	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/13/13
9. AGE (In years lost birthday) 42 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Wholesale House	
11. BIRTHPLACE (State or foreign country) Windsor, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Turner Speller		14. MOTHER'S MAIDEN NAME Norsise Hoggard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-II		16. SOCIAL SECURITY NO. 214 03 1969	
17. INFORMANT CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ANEMIA SECONDARY TO ABOVE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 11 , 19 56 , to Aug. 2 , 19 56 , and that death occurred 6:55 P.M. from the causes and on the date stated above. XXXXXX ADDRESS (Street, city or town, state) VAH, Fort Howard, Md. DATE SIGNED 8/3/56 ACTUAL SIGNATURE F. S. Dickey M.D. PHYSICIAN'S NAME (Type) FRANCIS G. DICKEY, M.D. CHIEF, MEDICAL SERVICE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/5/56	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy Wilson		24a. REC'D BY REGISTRAR AUG 13 1956	
ADDRESS 1000 Brentley Ave. Balto, Md.		24b. REGISTRAR'S SIGNATURE Dawson L. Fisher	

CERTIFICATE OF DEATH

Name of Deceased		John Doe	
Age		45	
Sex		Male	
Race		Caucasian	
Marital Status		Married	
Occupation		Teacher	
Usual Residence		123 Main St, Baltimore, Md.	
Cause of Death		Heart Disease	
Date of Death		August 10, 1955	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

BUREAU V. E.

AUG 13 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8108
CERTIFICATE OF DEATH

08084 38
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson (Baynesville)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson (Baynesville)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1909 E. Joppa Road		d. STREET ADDRESS 1909 E. Joppa Road	
3. NAME OF DECEASED (Type or print) First MILLARD Middle FILMORE Last STIFFIER		4. DATE OF DEATH Month August Day 7 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1876
9. AGE (In years and birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 19	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Co. Sewage Dept.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) degenerative Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Age			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Age			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month June Day 19 Year 1954 Hour o. m. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19, 1954 to Aug 7, 1956 , that I last saw the deceased alive on June 19, 1954 , and that death occurred at 9:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9005 HARFORD RD. DATE SIGNED Aug 13 1956			
ACTUAL SIGNATURE F.T. KASIR, JR. M.D.			
PHYSICIAN'S NAME (Type) F.T. KASIR, JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 10, 1956	22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	22d. LOCATION (City, town, or county) (State) Parkville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John Burkholder ADDRESS Towson, Md.		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE Mabel Gray

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

8103

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES J. JONES		45		M		W		1913		NEW YORK		NEW YORK		UNITED STATES	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
1000 N. 10th St.		Salesman		Heart Disease		Natural		1956		New York		New York		United States	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
1956		New York		New York		United States		1956		New York		New York		United States	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
1956		New York		New York		United States		1956		New York		New York		United States	

BUREAU V. 3

JUN 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8109

CERTIFICATE OF DEATH

08085

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 41 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland d. STREET ADDRESS Conklin Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle John Last Stone				4. DATE OF DEATH Month August Day 7 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/15/07	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph I. Stone (deceased)				14. MOTHER'S MAIDEN NAME Lizzie Miller (deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Rosewood Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute and Chronic aspiration pneumonia DUE TO Difficulty in swallowing Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral palsy and Idiocy due to birth injury DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March , 19 55 , to August , 19 56 , that I last saw the deceased alive on August 7 , 19 56 , and that death occurred at 9:52 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Rich. Lindenb. (Pathologist) M.D.				ADDRESS (Street, city or town, state) 700 Fleet Street, Baltimore 2, Md.			
DATE SIGNED							
PHYSICIAN'S NAME (Type) Richard Lindenberg, Pathologist				700 Fleet Street, Baltimore 2, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Aug 10/56		22c. NAME OF CEMETERY OR CREMATORY Rosewood		22d. LOCATION (City, town, or county) (State) Owings Mills Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline Sons Rustertown				ADDRESS		24a. REC'D BY REGISTRAR 8-10-56	
24b. REGISTRAR'S SIGNATURE Mary B. Eline							

BUREAU V. 81

AUG 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8110

CERTIFICATE OF DEATH

08086

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>69 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1956</u>				5. STREET ADDRESS <u>630 Sarah Ann Street</u>			
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>(NMI)</u> Last <u>SUTTON</u>				6. DATE OF BIRTH <u>August 27, 1895</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) yrs. <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building contractor</u>		11. BIRTHPLACE (State or foreign country) <u>Tarboro, N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Sutton</u>				14. MOTHER'S MAIDEN NAME <u>Addie MN: Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>705-12-6744</u>		17. INFORMANT Address <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MELANOSARCOMA, RIGHT LUNG</u> 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 12</u> , 19 <u>56</u> , to <u>August 20</u> , 19 <u>56</u> , that he last saw the deceased alive on <u>August 19</u> , and that death occurred at <u>1:40 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Irving Freeman</u> M.D. <u>VA HOSPITAL, FORT HOWARD, MARYLAND</u>				8/21/56			
PHYSICIAN'S NAME (Type) <u>IRVING FREEMAN, M.D., Acting Chief, Medical Service</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-24-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> ADDRESS <u>802-04 Madison Ave. Balto. 1 Md.</u>				24a. REC'D BY REGISTRAR <u>Aug 23-56</u>		24b. REGISTRAR'S SIGNATURE <u>Nanewen L. Parker</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN SHIPSON		MARRIAGE None		DATE OF BIRTH 1910		PLACE OF BIRTH Maryland	
SEX Male		RACE White		EDUCATION High School		OCCUPATION None	
DATE OF DEATH 1956		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
AGE 46		SEX Male		RACE White		EDUCATION High School	
DATE OF BIRTH 1910		PLACE OF BIRTH Maryland		OCCUPATION None		MARRIAGE None	
NAME OF DECEASED JOHN SHIPSON		MARRIAGE None		DATE OF BIRTH 1910		PLACE OF BIRTH Maryland	
SEX Male		RACE White		EDUCATION High School		OCCUPATION None	
DATE OF DEATH 1956		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
AGE 46		SEX Male		RACE White		EDUCATION High School	
DATE OF BIRTH 1910		PLACE OF BIRTH Maryland		OCCUPATION None		MARRIAGE None	

BUREAU V. S.

1956

RECEIVED

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roebling			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 111 Alcock Road				d. STREET ADDRESS 15 Third Ave.			
3. NAME OF DECEASED (Type or print) First THERESA Middle B. Last SYLVASAN				4. DATE OF DEATH Month August Day 22 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 20, 1887	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Austria	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Belma				14. MOTHER'S MAIDEN NAME Mary Mary			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT John Sylvasan Address 15 Third Ave, Roebling, N.J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 3 , 19 56 to Aug 27 , 19 56 , that I last saw the deceased alive on Aug 21 , 19 56 , and that death occurred at 1 A. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A. L. Kolodny		M.D. 1825 Eastern Blvd		ADDRESS (Street, city or town, state) Balt-21, Md		DATE SIGNED 8/22/56	
PHYSICIAN'S NAME (Type) A. L. Kolodny M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 22, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Roebling, N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.				ADDRESS 4210 Belair Road.		24a. REC'D BY REGISTRAR AUG 23 1956	
				24b. REGISTRAR'S SIGNATURE Edith Hurley			

RECEIVED

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 22 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 816 N. Montford Ave.			
3. NAME OF DECEASED (Type or print) First RICHARD Middle (NMI) Last TABORSKY				4. DATE OF DEATH Month August Day 25 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/25/03	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Taborsky				14. MOTHER'S MAIDEN NAME Josephine Matousek			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Clin./Rec.Vet.Adm.Hosp., Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CACHEXIA WITH INANITION DUE TO CARCINOMA OF THE PANCREAS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE						INTERVAL BETWEEN ONSET AND DEATH 1 MONTH 6 Months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 3 , 19 56 , to August 25 , 19 56 , and that death occurred at 9:00 A. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Armen Bogosian M.D.				ADDRESS (Street, city or town, state) VAH, Fort Howard, Md. DATE SIGNED 8/25/56			
PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN, M.D.				VAH, Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/28/56		22c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Schimunek Funeral Home, Inc. Inverne & Madison Sts. Baltimore, Maryland				24a. REC'D BY REGISTRAR DATE 8/28/56		24b. REGISTRAR'S SIGNATURE D. Dawson	

CERTIFICATE OF DEATH

Name of Deceased		Date of Death		Place of Death	
John Doe		12/15/1956		New York, N.Y.	
Age		Sex		Race	
45		Male		White	
Marital Status		Cause of Death		Manner of Death	
Married		Heart Disease		Natural	
Occupation		Signature of Physician		Signature of Registrar	
Teacher		[Signature]		[Signature]	
Residence		Date of Burial		Place of Burial	
123 Main St.		12/16/1956		Cemetery	

Name of Deceased		Date of Death		Place of Death	
John Doe		12/15/1956		New York, N.Y.	
Age		Sex		Race	
45		Male		White	
Marital Status		Cause of Death		Manner of Death	
Married		Heart Disease		Natural	
Occupation		Signature of Physician		Signature of Registrar	
Teacher		[Signature]		[Signature]	
Residence		Date of Burial		Place of Burial	
123 Main St.		12/16/1956		Cemetery	

BUREAU V. 3

AUG 28 1956

RECEIVED

Name of Deceased		Date of Death		Place of Death	
John Doe		12/15/1956		New York, N.Y.	
Age		Sex		Race	
45		Male		White	
Marital Status		Cause of Death		Manner of Death	
Married		Heart Disease		Natural	
Occupation		Signature of Physician		Signature of Registrar	
Teacher		[Signature]		[Signature]	
Residence		Date of Burial		Place of Burial	
123 Main St.		12/16/1956		Cemetery	

8113

Item 7 FilmG202 9-6-56 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chattolonee		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chattolonee		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Admiral Bells Residence				d. STREET ADDRESS Chattolonee Rd.			
3. NAME OF DECEASED (Type or print) First SAMUEL Middle E. Last TODD				4. DATE OF DEATH Month August Day 22 Year 1956			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY Morgan College		11. BIRTHPLACE (State or foreign country) S. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Highman Todd				14. MOTHER'S MAIDEN NAME Hattie Boyd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Cassie Todd - 914 N. Eden			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary occlusion (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		8/23/56	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
burial		8-26-56		Mt Calvary		Brooklyn Md	
23. FUNERAL DIRECTOR'S SIGNATURE Eloy D. Wilson				ADDRESS Brooklyn Md		24a. REC'D BY REGISTRAR AUG 30 1956	
						24b. REGISTRAR'S SIGNATURE A. H. Hedrick	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NAVY AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		REMARKS	
1000	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
...		

RECEIVED
 AUG 31 1956
 BUREAU V. 81

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08090

8114

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG201 8-15-56 et

Reg. Dist. No.

30

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DIST. OF COLUMBIA COUNTY WASHINGTON, D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b 23 Yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14 SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 47X-3			
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL GILBERT TRUSLER				4. DATE OF DEATH Month Day Year AUGUST 4 19 56			
5. SEX male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 21, 1905	
9. AGE (In years last birthday) 50 51 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL TRUSLER				14. MOTHER'S MAIDEN NAME MARGARET CARR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Address Records- Spring Grove State Hosp ital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardiovascular Disease (c) 420.1 DUE TO Arteriosclerotic Cardiovascular Disease cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Public		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Loyitt, Jr				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Loyitt, Jr				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried Aug 9 1956		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Georgetown		22d. LOCATION (City, town, or county) (State) Hyattsville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Daniel Funeral Home				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR Aug 9 1956	
						24b. REGISTRAR'S SIGNATURE V. E. Harvey	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

BUREAU V. 8

AUG 9 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 10

8115

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Hart.</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Catonsville</i>	LENGTH OF STAY (in this place) <i>6 mo 16 days</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Aberdeen</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Spring Grove St. Hosp. Catonsville Md.</i>	STREET ADDRESS (If rural give location) <i>Route #1</i>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <i>Annie</i>	(Middle) <i>R.</i>	(Last) <i>Turner</i>	OF DEATH: <i>8/12/1956</i>
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>W.</i>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <i>Widow</i>	8. DATE OF BIRTH: <i>3/18/1871</i>
9. AGE last birthday: <i>85</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	11. BIRTHPLACE (State or foreign country): <i>U.S.A.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME: <i>George Crestwell</i>	
14. MOTHER'S MAIDEN NAME: <i>Margaret Dolan</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>	
16. SOCIAL SECURITY NO. <i>unk.</i>		17. INFORMANT & ADDRESS: <i>This Hospital's Records</i>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <i>Coronary Occlusion</i>		<i>few minutes</i>	
(B) <i>Arteriosclerosis of heart vessels</i>		<i>for many years</i>	
(C) <i>Generalized arteriosclerosis</i>		<i>for many years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Cotter of the Thyroid</i>			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1/26</i> , 1956, to <i>8/12</i> , 1956, that I last saw the deceased alive on <i>8/11</i> , 1956, and that death occurred at <i>5:15 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Bruno Radauskas</i>		DATE SIGNED <i>8/12/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Aug. 15, 1956</i>	NAME OF CEMETERY OR CREMATORY <i>Mountain Christian</i>
DATE REC'D BY LOCAL REGISTRAR <i>AUG 15 1956</i>		REGISTRAR'S SIGNATURE <i>V. E. Harry</i>	24. FUNERAL DIRECTOR <i>Joe T. Foster</i>
		ADDRESS <i>Foster Funeral Home, W. Broadway, B.E. Air, Md.</i>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU Y. S.

AUG 16 1956

RECEIVED

8116 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> <u>435 E. PENNA. AVE. TOWSON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN TB <u>3 Months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>435 E. PENNA. AVE</u>				d. STREET ADDRESS <u>435 E. PA. AVE</u>			
3. NAME OF DECEASED (Type or print) <u>LESTER RANDOLPH TYLER JR.</u> First Middle Last				4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 8, 1956</u>		9. AGE (in years last birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LESTER JOHNSON</u>				14. MOTHER'S MAIDEN NAME <u>LILLIAN TYLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>LILLIAN TYLER - 435 E. PENNA. AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE OTITIS MEDIA</u> DUE TO 391.0 Conditions, if any, which gave rise to immediate cause (b) <u></u> (c), stating the underlying cause last. DUE TO <u></u> INTERVAL BETWEEN ONSET AND DEATH <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. S. FISHER</u>				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R. S. FISHER</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/21/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT REST</u>		22d. LOCATION (City, town, or county) (State) <u>TOWSON, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Chaturvedi - 1701 M. & Calhoun St.</u>				24a. REC'D BY REGISTRAR DATE <u>8/20/56</u>		24b. REGISTRAR'S SIGNATURE <u>Metel Kuy</u>	
ADDRESS <u>Balto. MD.</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
DISEASE OR INJURY		DIAGNOSIS		TREATMENT		POST-MORTEM		OTHER	
SIGNATURE OF EXAMINER		DATE		PLACE		CITY		STATE	

BUREAU V. S.

AUG 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08093

8117

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall Nursing Home		d. STREET ADDRESS Rexis Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Paul Middle E. Last Ulrich		4. DATE OF DEATH Month Aug. Day 5 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer-Retired		10b. KIND OF BUSINESS OR INDUSTRY P. R. R.	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick Ulrich		14. MOTHER'S MAIDEN NAME Wilhelmina Kroll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 717-07-8646	
17. INFORMANT Emmett P. Ulrich		Address 7304 Belair Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Carcinoma 153x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized metastases DUE TO (c) CA of colon		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/9, 1956 to present , 19 56 , that I last saw the deceased alive on 7/30, 1956 , and that death occurred at 6:27 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Cameron		ADDRESS (Street, city or town, state) 30 Chandelle Rd. Greenv, Md.	
DATE SIGNED 8/5/56			
PHYSICIAN'S NAME (Type) Joseph Cameron			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 8, 1956	
22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR Aug 8 1956		24b. REGISTRAR'S SIGNATURE Edith Hurley	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANCE	
APRIL 4, 1968		MEMPHIS, TENNESSEE		SHOOTING		SUICIDE		GUNSHOT WOUNDS		YES	
TIME OF DEATH		HOURS		MINUTES		SECOND		TEMPERATURE		PULSE	
10:00 AM		10		00		00		98.6		60	
DATE OF BURIAL		PLACE OF BURIAL		CITY		STATE		COUNTRY		CEMETERY	
APRIL 8, 1968		MEMPHIS		TENNESSEE		UNITED STATES				SOUTH MEADOWS	
NAME OF FUNERAL HOME		ADDRESS		CITY		STATE		COUNTRY		ZIP CODE	
JAMES EARL RAY FUNERAL HOME		1234 MAIN ST		MEMPHIS		TENNESSEE		UNITED STATES		38101	
NAME OF PHYSICIAN		ADDRESS		CITY		STATE		COUNTRY		ZIP CODE	
DR. JAMES EARL RAY		1234 MAIN ST		MEMPHIS		TENNESSEE		UNITED STATES		38101	
NAME OF CORONER		ADDRESS		CITY		STATE		COUNTRY		ZIP CODE	
DR. JAMES EARL RAY		1234 MAIN ST		MEMPHIS		TENNESSEE		UNITED STATES		38101	
NAME OF WITNESS		ADDRESS		CITY		STATE		COUNTRY		ZIP CODE	
DR. JAMES EARL RAY		1234 MAIN ST		MEMPHIS		TENNESSEE		UNITED STATES		38101	

BUREAU V. S.

AUG 8 1956

RECEIVED

CERTIFICATE OF DEATH

08094

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				c. LENGTH OF STAY IN 1b 1 mo. 30 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle C. Last Verderaime				4. DATE OF DEATH Month 8 Day 13 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-22-1895	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months 6 Days 13	IF UNDER 24 HRS. Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert Verderaime				14. MOTHER'S MAIDEN NAME Teresa Russell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Records of Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease, 422.1 DUE TO generalized arteriosclerosis, generalized and severe. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 14 , 19 56 , to August 13 , 19 56 , that I last saw the deceased alive on August 13 , 19 56 , and that death occurred at 10:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) Spring Grove State Hospital Baltimore 28, Maryland		DATE SIGNED 8-13-56	
PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 17, 1956		22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Jr.				ADDRESS 1217 ST. PAUL ST.		24a. REC'D BY REGISTRAR DATE 14 1956	
				24b. REGISTRAR'S SIGNATURE T. E. Harry			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
AUG 15 1956
BUREAU V. 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08095

8119

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN <u>11 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE Gertrude WAGNER</u>		4. DATE OF DEATH Month Day Year <u>Aug. - 19-56</u> 19	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-9-1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR: Months <u>2</u> Days <u>10</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN WAGNER</u>		14. MOTHER'S MAIDEN NAME <u>KIRK (maiden)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Herbert Wagner 7034 Windsorhill Rd.</u>	
17. INFORMANT Address <u>Herbert Wagner 7034 Windsorhill Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerotic cardiovascular</u> DUE TO <u>disease</u> (c) <u>disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-13-55</u> , 19 <u>55</u> , to <u>8-19-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-19-56</u> , 19 <u>56</u> , and that death occurred at <u>7:15 P.M.</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Spring Grove Hospital</u> DATE SIGNED <u>8-19-56</u>	
ACTUAL SIGNATURE <u>David Edwards MD</u> M.D.		PHYSICIAN'S NAME (Type) <u>DAVID EDWARDS MD</u> <u>Spring Grove Hospital</u> <u>8-19-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/22/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE</u>		22d. LOCATION (City, town, or county) (State) <u>RANDALLSTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stenhouse</u> ADDRESS <u>44 Windsor Mill Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>8/24/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Victor C. Harry</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

8120

CERTIFICATE OF DEATH

Reg. Dist. No. 38

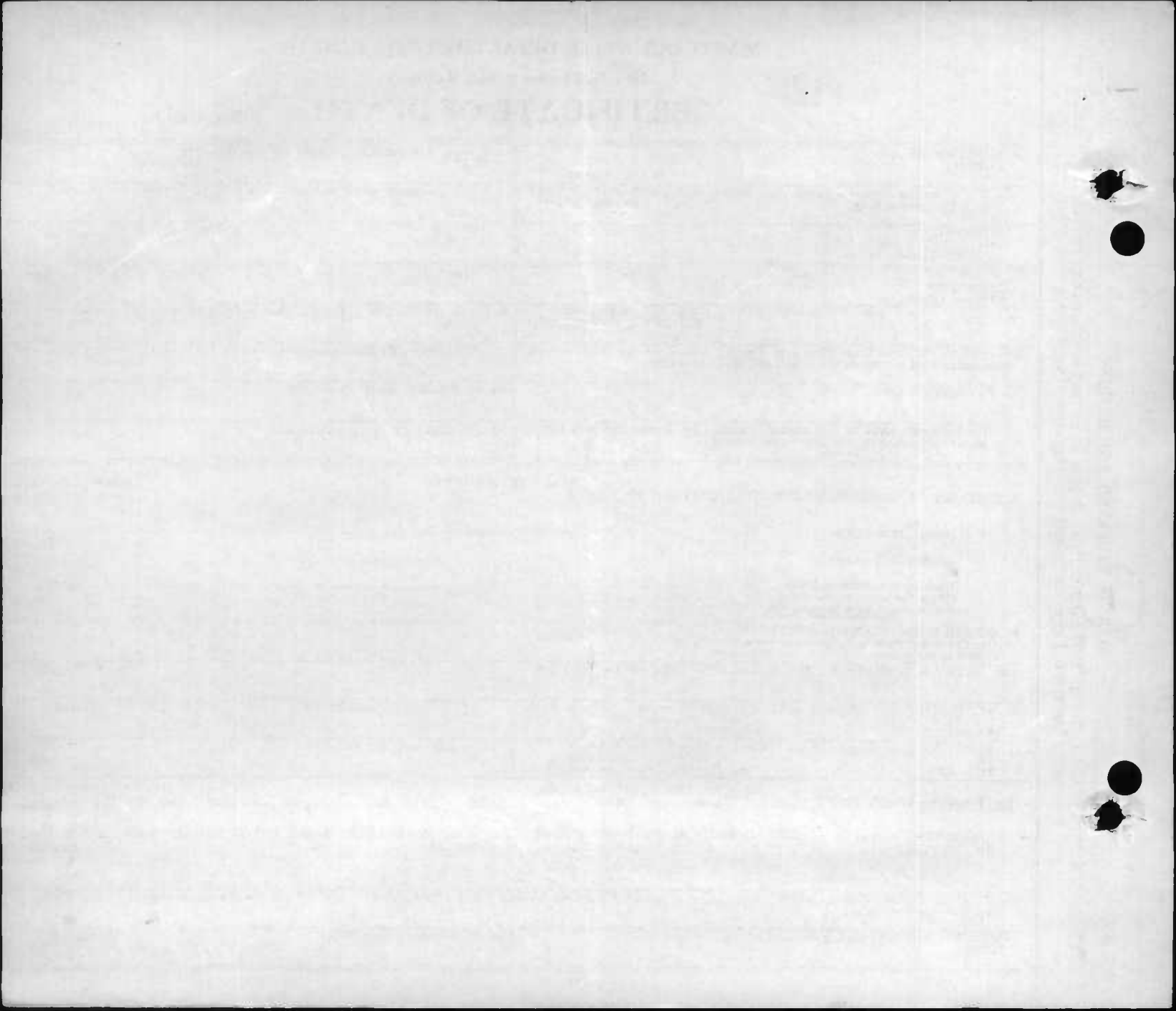
1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>6810 Pinchurst</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Henry</u> (Middle) <u>Nicholas</u> (Last) <u>Wagner</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 15</u> 19 <u>56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>June 24 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Woolen</u>	9. AGE last birthday <u>65</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Albert Wagner</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>887-09-3146</u>	
17. INFORMANT AND ADDRESS <u>GERTRUDE 6810 Pinchurst, Balt.</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Wagner</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
Immediate cause <u>(a) Carcinoma of colon</u>					
Antecedent cause(s) <u>(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>					
II. OTHER SIGNIFICANT CONDITIONS <u>(c) Conditions contributing to the death but not related to the disease or condition causing death.</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 10</u> , 19 <u>56</u> to <u>Aug 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 15</u> , 19 <u>56</u> , and that death occurred at <u>10 A</u> m., from the causes and on the date stated above.					
SIGNATURE <u>Henry N. Wagner, Jr.</u>		ADDRESS <u>Bethesda, Md.</u>		DATE SIGNED <u>Aug 15 1956</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>Aug 18-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem</u>	
LOCATION (City, town, or county) <u>Baltimore</u>		(State) <u>Md</u>		24. FUNERAL DIRECTOR <u>Frederick Rd</u>	
DATE REC'D BY LOCAL REG. <u>8/17/56</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>		ADDRESS <u>Suppel Bros. 7110 Belair Rd</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

08097

Reg. Dist. No. 30

8121

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>305 S. Rolling Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mules Conv. Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROBERT ALVIN WAGNER</u>				4. DATE OF DEATH <u>Aug 19</u> 19 <u>56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 3, 1874</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ra</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wagner</u>				14. MOTHER'S MAIDEN NAME <u>Anna Lawler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs Emily Wagner</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory failure</u> 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Uremia</u> DUE TO (c) <u>Enterosclerotic Nephrosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>56</u> , to <u>19 Aug.</u> 19 <u>56</u> , that I last saw the deceased alive on <u>19 Aug.</u> 19 <u>56</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William J. Bryson</u> M.D.				DATE SIGNED <u>4/6/56</u>			
PHYSICIAN'S NAME (Type) <u>William J. Bryson</u>				ADDRESS (Street, city or town, state) <u>4605 Edmonson Ave</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Entombment</u>		<u>8/24/56</u>		<u>Lorraine</u>		<u>Balto Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McNabb & Son</u> ADDRESS <u>28</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>8/22/56</u>		<u>V.E. Harry</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AUG 23 1956

RECEIVED

8122

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowley's Quarters				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowley's Quarters			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Box 706 - Seneca Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MICHAEL Middle K. Last WALDHAUSER				4. DATE OF DEATH Month August Day 25 Year 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 15, 1872	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired clerk				10b. KIND OF BUSINESS OR INDUSTRY City Electrician Board		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Michael C. Waldhauser				14. MOTHER'S MAIDEN NAME Barbara Furst			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Helen Vavra Waldhauser, wife, above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X cerebral embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chr. myocarditis + endocarditis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arterio-sclerosis, mild hypertension, aneurysm						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 14 , 19 56 , to Aug. 25 , 19 56 , that I last saw the deceased alive on Aug. 24 , 19 56 , and that death occurred at 10:20 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. C. Dobihal		M.D. 447 H. Kenwood Ave.		ADDRESS (Street, city or town, state) Baltimore, Md.		DATE SIGNED 8/27/56	
PHYSICIAN'S NAME (Type) L. C. Dobihal, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/28/56		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, Inc.				ADDRESS 2601-3-5 E. Madison St.		24a. REC'D BY REGISTRAR DATE 8/28/56	
				24b. REGISTRAR'S SIGNATURE Dr. Samuel P. Carls			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08099

8123

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 20 W. Elm Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Overlea, Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ERNESTINE Middle WALLUT Last		4. DATE OF DEATH Month August Day 24 , Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1880
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Kalal		14. MOTHER'S MAIDEN NAME Josephine Koleha	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Elsie Buhl, dhgt. 20 W. Elm Avenue		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Metastatic abdomen 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma, Lungs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 11, 1956 , to Aug 24, 1956 that I last saw the deceased alive on Aug 24, 1956 , and that death occurred at 11 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles V. Sevcik M.D.		ADDRESS (Street, city or town, state) 5701 Belair Rd DATE SIGNED 8/25/56	
PHYSICIAN'S NAME (Type) 5101 Belair Road, Charles V. Sevcik			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 28, 1956	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Schmunek Funeral Home, Inc. 2601-3-5 E. Madison St.		24a. REC'D BY REGISTRAR DATE 8/28/56	
24b. REGISTRAR'S SIGNATURE A. P. Ruffenidas			

CERTIFICATE OF DEATH

NAME OF DECEASED BAGLEY, JAMES		SEX MALE		AGE 35 YRS		DATE OF BIRTH JAN 15, 1920	
PLACE OF BIRTH BALTIMORE, MD		OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
RESIDENCE 1234 E. BALTIMORE ST		DATE OF DEATH AUG 23, 1956		HOURS OF DEATH 10:00 AM		PLACE OF DEATH HOME	
NAME OF PHYSICIAN DR. J. H. SMITH		NAME OF FUNERAL HOME JOHNSON & SONS		NAME OF BURIAL PLACE GREENWOOD CEMETERY		DATE OF BURIAL AUG 25, 1956	
SIGNATURE OF PHYSICIAN J. H. SMITH		SIGNATURE OF FUNERAL HOME JOHNSON & SONS		SIGNATURE OF DECEASED JAMES BAGLEY		SIGNATURE OF WITNESS JOHN DOE	

BUREAU V. 1

AUG 23 1956

RECEIVED

2501 E. BALTIMORE ST. BALTIMORE, MD

BAGLEY, JAMES, 35 YRS, 1920

SCHMIDT & SONS, INC.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08100	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 33	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND										2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glydon	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Piney Grove Road					d. STREET ADDRESS Bond & Central Avenues					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Virginia Middle Theresa Last Webb										4. DATE OF DEATH Month August Day 15 Year 1956	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 13, 1916		9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months 39 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert Rising						14. MOTHER'S MAIDEN NAME Katherine Caler					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-05-8383		17. INFORMANT Address Harold L. Webb, Glyndon, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Chest 919.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot in Chest							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8-15-56 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Yard		20f. (City or town) Reisterstown		20g. (County) Baltimore	
20h. (State) Md.											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE <i>Paul F. Guerin</i>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED 8/15/56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Aug. 18, 1956		22c. NAME OF CEMETERY OR CREMATORY Woodlawn				22d. LOCATION (City, lawn, or county) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.						24a. REC'D BY REGISTRAR 8-16-56		24b. REGISTRAR'S SIGNATURE <i>Mary B. Eline</i>			

BP

BUREAU V. 3

AUG 20 1956

RECEIVED

08104

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLYNDON</u>		c. LENGTH OF STAY IN 1b <u>2 MONTHS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>IRENE HENRIETTA WENCHEL</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 4 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 12, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>GEORGE YEARLY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MR. LAWRENCE WENCHEL</u>		Address <u>BALTIMORE 13</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPER TENSION</u> (c) <u>ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> YEARS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 29, 1956</u> , to <u>Aug 4, 1956</u> , that I last saw the deceased alive on <u>August 4, 1956</u> , and that death occurred at <u>3:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clarence E. McWilliams</u> M.D.		ADDRESS (Street, city or town, state) <u>Reisterstown Maryland</u> DATE SIGNED <u>Aug 4/1956</u>	
PHYSICIAN'S NAME (Type) <u>CLARENCE E. McWilliams</u>		<u>REISTERSTOWN Maryland Aug 4/1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7/7/56</u>	<u>MA Barmel Inn</u>	<u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip Newington</u>		24a. REG'D BY REGISTRAR <u>2024 Calens</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>May Elise</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED NEWELL, ELLIS WENDELL		2. SEX M		3. AGE 38		4. DATE OF BIRTH JAN 15 1918	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION ENGINEER		7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE JULY 15 1945	
9. CAUSE OF DEATH CORONARY THROMBOSIS		10. PLACE OF DEATH HOME		11. TIME OF DEATH 10:15 AM		12. DATE OF DEATH AUG 5 1956	
13. SIGNATURE OF PHYSICIAN J. H. [illegible]		14. SIGNATURE OF WITNESSES [illegible]		15. SIGNATURE OF DECEASED [illegible]		16. SIGNATURE OF FUNERAL HOME [illegible]	
17. SIGNATURE OF REGISTRAR [illegible]		18. SIGNATURE OF CLERK [illegible]		19. SIGNATURE OF [illegible] [illegible]		20. SIGNATURE OF [illegible] [illegible]	

BUREAU V. S.

AUG 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8126

CERTIFICATE OF DEATH

08102

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LEDGE FOREST (19)</u> 9 MO.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LEDGE FOREST. (BALTO. 19)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2108 CREEK RD</u>		d. STREET ADDRESS <u>2108 CREEK RD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LEROY FRANKLIN WESTBROOK, SR</u>		4. DATE OF DEATH Month <u>8</u> - Day <u>20</u> - Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 3, 1910</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFG.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WM. WESTBROOK</u>		14. MOTHER'S MAIDEN NAME <u>ELLA McHAZEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-01-3872</u>	
17. INFORMANT <u>VIRGINIA F. WESTBROOK</u>		Address <u>— SAME —</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V. Disease</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>Aug 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 20</u> , 19 <u>56</u> , and that death occurred at <u>1140A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James T. Means</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>570 D. St. Balt. Md</u> <u>8/24/56</u>	
PHYSICIAN'S NAME (Type) <u>James T. Means</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>8-23-56</u>	<u>OHK LAWN</u>	<u>BALTO. CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry Brooks-Brooklyn, Brooklyn, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 23 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>James L. Parker</u>			

CERTIFICATE OF DEATH

1956

USE THE NO.

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The text is mostly illegible due to blurring and bleed-through.

BUREAU V. B.

AUG 23 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08103

8127

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville</u>				TOWN <u>Baltimore</u>		3101-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Caton Ridge Nursing Home</u>				STREET ADDRESS (If rural give location) <u>2032 W. Lanvale St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u>		(Middle) <u>J.</u>		(Last) <u>Wilkinson</u>		(Month) (Day) (Year) <u>Aug. 16 1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Oct. 24, 1877</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>At home</u>				<u>Baltimore, Md.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>-----</u>		<u>Caton Ridge Nursing Home</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
153X IMMEDIATE CAUSE (A) <u>Intestinal obstruction</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cancer of bowel large</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May, 1956</u> , to <u>Aug. 16, 1956</u> , that I last saw the deceased alive on <u>Aug. 14, 1956</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>C. E. Karetz J.</u>				ADDRESS (Street, city, town, state) <u>M.D. 4605 Edmondson Ave.</u>		DATE SIGNED <u>8/20/1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/18/56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>T. E. Gary</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u> ADDRESS <u>-4600 Liberty Hgts.</u>			

AUG 24 1956

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

PLACE OF BIRTH _____		PLACE OF DEATH _____	
DATE OF BIRTH _____		DATE OF DEATH _____	
SEX _____		RACE _____	
MARRIAGE _____		OCCUPATION _____	
NAME OF DECEASED _____		NAME OF REPORTER _____	
ADDRESS _____		CITY _____	
COUNTY _____		STATE _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____	
MEDICAL HISTORY _____		SOCIAL HISTORY _____	
SIGNATURE OF REPORTER _____		SIGNATURE OF DECEASED _____	
DATE OF REPORT _____		TIME OF REPORT _____	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased. It should be filled out as soon as possible after death, and should be filed with the local health department or the State Department of Health. A copy of this certificate should be sent to the funeral home or other person in charge of the funeral.

BUREAU V. 2

AUG 24 1956

RECEIVED

09166

STATE DEPARTMENT OF HEALTH

MARYLAND

8128

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE, MD.</u> TOWN <u>CATONSVILLE</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6208 FREDERICK RD.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>BALTO.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CATONSVILLE</u> STREET ADDRESS (If rural, give location) <u>6208 FREDERICK RD.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>LURETTA</u>	(Middle)	(Last) <u>WILLGROUBS</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>W, DOW</u>	8. DATE OF BIRTH <u>FEB 28, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	9. AGE last birthday <u>71</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN SCHLOTE</u>		14. MOTHER'S MAIDEN NAME <u>AMELIA WILHELM</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>---</u>	
17. INFORMANT AND ADDRESS <u>Irvin A. Willgrobs - 6208 Frederick Rd.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>420.1 Coronary Thrombosis</u>		Generalized arterio sclerosis. Hypertensive cardio-vascular disease. Chronic myocardial dis. with cardiac hypertrophy and congestive failure.	10 minutes
Antecedent cause(s) (b) <u>Generalized arterio sclerosis.</u>			Several years.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertensive cardio-vascular disease.</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>hypertrophy and congestive failure</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, or office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

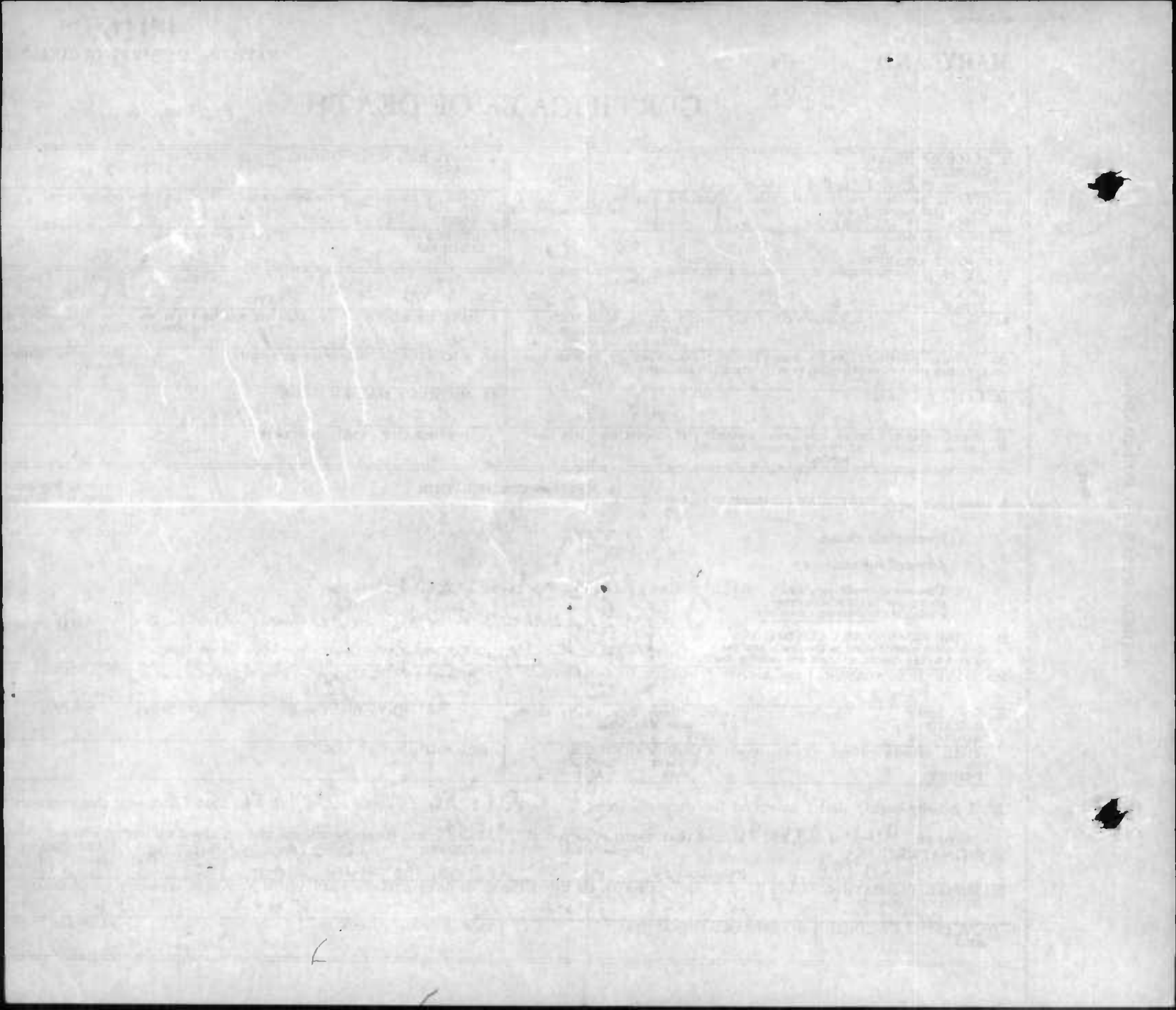
22. I hereby certify that I attended the deceased from March 1, 1956, to August 24, 1956, that I last saw the deceased alive on August 23, 1956, and that death occurred at 7:55 P.M., from the causes and on the date stated above.

SIGNATURE William Michael M.D. (Degree or title) ADDRESS Baltimore 16, Md DATE SIGNED Aug 24, 1956

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 8-28-56 NAME OF CEMETERY OR CREMATORY Landon Park Cem. LOCATION (City, town, or county) Balto. (State) MD.

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE --- 24. FUNERAL DIRECTOR Swley Funeral Home - Catonsville, Md. ADDRESS ---

MARGIN RESERVED FOR BINDING



8129

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD,				c. LENGTH OF STAY IN 1b 112 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle P Last WILSON				4. DATE OF DEATH Month August Day 1 Year 19 56			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-2-96	
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Wilson				14. MOTHER'S MAIDEN NAME Margaret Anthony			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-1		17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THORACOPLASTY, RIGHT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) EMPHYEMA, RIGHT DUE TO (c) PNEUMONIA, RIGHT LOWER LOBE				INTERVAL BETWEEN ONSET AND DEATH 9 DAYS 6 WEEKS 8 WEEKS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RIGHT HEMIPLEGIA				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Baltimore		20h. (State) Maryland	
21. I certify that VA attended the deceased from April 11, 19 56 , to August 1 19 56 . He died on August 1, 1956 at 1:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 8-2-56 ACTUAL SIGNATURE Irving Freeman M.D. VAH, Fort Howard, Maryland PHYSICIAN'S NAME (Type) IRVING FREEMAN M.D. VAH, Fort Howard, Maryland 8-2-56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/6/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Mortuary, 802-04 Madison Ave. Balto.				24a. REC'D BY REGISTRAR DATE 8/7/56		24b. REGISTRAR'S SIGNATURE Dawson P. Kiser	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in operation within 72 hours after death.

RECEIVED
AUG 8 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8130

CERTIFICATE OF DEATH

Reg. Dist. No.

08105
332

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Millers</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Millers</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gunpowder Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Isaac Columbus Wilt</u>		4. DATE OF DEATH <u>August 29, 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bittinger, Md.</u>	
13. FATHER'S NAME <u>John Wilt</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-22-4398</u>	
17. INFORMANT <u>Mrs. Samuel Dudley Miller, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arterio-sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>7/5</u> , 19 <u>56</u> , to <u>8/29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/29/56</u> , 19 <u>56</u> , and that death occurred at <u>12:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. M. France</u> M.D.		ADDRESS (Street, city or town, state) <u>Parkton, Md.</u> DATE SIGNED <u>8/29/56</u>	
PHYSICIAN'S NAME (Type) <u>Dr. A. M. France</u>		<u>Parkton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug. 31, 1956</u>		22b. DATE THEREOF <u>Aug. 31, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>White Plains Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Wilt</u> ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>8/31/56</u> 24b. REGISTRAR'S SIGNATURE <u>Isaac Wilt</u>	

BUREAU V. 3

SEP 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG201 8-20-56 et.

08196
38

8131

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				d. STREET ADDRESS <u>8707 Maravoss Lane</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>W.</u> Last <u>Wiseman</u>				4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 17, 1876</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Carrier-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. Wiseman</u>				14. MOTHER'S MAIDEN NAME <u>Mary R. Wilkinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Barbara Wiseman 8707 Maravoss Lane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>August</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug. 7</u> , 19 <u>56</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8100 Harford Rd., Balt., 14 Md.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>William Cook, Jr.</u> M.D. _____ PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 11, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Jr.</u> ADDRESS <u>1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>AUG 13 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. L. M. Bacon</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

County of Baltimore

Certificate No. 10

City of Baltimore

777 North Avenue

Residence

Occupation

Age

Sex

Color

Religion

Married

Single

Cause of Death

Place of Death

Signature

Witness

BUREAU V. E.

AUG 13 1956

RECEIVED

Funeral Home

1217 St. Paul Street

081070

8132

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY Pr. Geo. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yrlmt22dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland		1615.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSP.		d. STREET ADDRESS 6920 Greenvale Pkwy.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle Witmyer Last Witmyer		4. DATE OF DEATH Month August Day 9 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 23, 1891
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ticket taker		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Adam Witmyer		14. MOTHER'S MAIDEN NAME Elvina Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 17 , 19 54 , to August 9 , 19 56 , that I last saw the deceased alive on August 9 , 19 56 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslor		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 8-9-56	
PHYSICIAN'S NAME (Type) Stella Wachslor, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/11/56	
22c. NAME OF CEMETERY OR CREMATORY George Washington		22d. LOCATION (City, town, or county) (State) Hyattsville Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Lasch's Sons-Hyattsville, Md.		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR Aug 10 1956		24b. REGISTRAR'S SIGNATURE T. E. Harry	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general office, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH Home		2. SEX Male		3. AGE 65		4. RACE White	
5. DATE OF DEATH July 13, 1956		6. TIME OF DEATH 10:00 AM		7. PLACE OF BIRTH Baltimore, Maryland		8. DATE OF BIRTH May 1, 1900	
9. NAME OF DECEASED John Doe		10. NAME OF FATHER John Doe		11. NAME OF MOTHER Jane Doe		12. NAME OF SPOUSE Mary Doe	
13. OCCUPATION Retired		14. CAUSE OF DEATH Heart Disease		15. MANNER OF DEATH Natural		16. SIGNATURE OF PHYSICIAN Dr. John Doe	
17. SIGNATURE OF DECEASED John Doe		18. SIGNATURE OF WITNESS Mary Doe		19. SIGNATURE OF PHYSICIAN Dr. John Doe		20. SIGNATURE OF REGISTRAR John Doe	

BUREAU V. 1

JUG 13 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

8133

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08108

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>3V01-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lochearn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>	
c. LENGTH OF STAY IN 1b <u>3-4 hrs</u>		d. STREET ADDRESS <u>707 E Fort Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3578 Forest Hill Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles F Wolcott</u>		4. DATE OF DEATH <u>Aug 11 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 15 1897</u>
9. AGE (In years last birthday) <u>59</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Phil Pa</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Wolcott</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Frederick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>2-12-16 0691</u>	
17. INFORMANT <u>Hein R Wolcott</u>		Address <u>707 E Fort Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary thrombosis</u> (c) <u>Coronary thrombosis</u> gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary thrombosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. E. McKieffer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Geo. E. McKieffer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Aug 13 56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 15 56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Balto md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edmund Funeral Home</u>		24. REG'D BY REGISTRAR <u>Aug 13 1956</u>	
ADDRESS <u>3631-3</u>		25. REGISTRAR'S SIGNATURE <u>Dr. Wm. E. Martin</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of Death: *Aug 10 1956*
5. Place of Death: *Home*
6. Cause of Death: *Heart Disease*
7. Manner of Death: *Natural*
8. Signature of Examiner: *[Signature]*
9. Date of Report: *Aug 15 1956*

BUREAU V. S.

AUG 15 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08109	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										20	
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BADONSVILLE					c. LENGTH OF STAY IN 1b 1 Month						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital					d. STREET ADDRESS 3310 Mayfair Road.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Eugene Wolfe					4. DATE OF DEATH August 5 19 56						
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 7, 1887		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist					10b. KIND OF BUSINESS OR INDUSTRY Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aquillia Wolfe					14. MOTHER'S MAIDEN NAME Ariana Cutsail						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 212 01 6186					17. INFORMANT Mrs. Sylvia Kies, 3310 Mayfair Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - Generalized DUE TO (c) 10 yrs.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE J. Nelson McKay					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) J. Nelson McKay					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					August 5, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Aug. 9/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet			22d. LOCATION (City, town, or county) (State) Frederick, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witte					ADDRESS 4101 Edmondson Ave.			24a. REC'D BY REGISTRAR Aug 8 1956		24b. REGISTRAR'S SIGNATURE J. E. Harry	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. LOCAL HEALTH OFFICE (Name and Address) _____
2. COUNTY HEALTH OFFICE (Name and Address) _____
3. CITY HEALTH OFFICE (Name and Address) _____
4. DISTRICT HEALTH OFFICE (Name and Address) _____
5. STATE HEALTH OFFICE (Name and Address) _____
6. DEPARTMENT OF HEALTH (Name and Address) _____
7. DEPARTMENT OF JUSTICE (Name and Address) _____
8. DEPARTMENT OF AGRICULTURE (Name and Address) _____
9. DEPARTMENT OF COMMERCE (Name and Address) _____
10. DEPARTMENT OF EDUCATION (Name and Address) _____
11. DEPARTMENT OF LABOR (Name and Address) _____
12. DEPARTMENT OF MINES (Name and Address) _____
13. DEPARTMENT OF NATURAL RESOURCES (Name and Address) _____
14. DEPARTMENT OF TRANSPORTATION (Name and Address) _____
15. DEPARTMENT OF WAREHOUSES (Name and Address) _____
16. DEPARTMENT OF WEAPONS (Name and Address) _____
17. DEPARTMENT OF WOODS (Name and Address) _____
18. DEPARTMENT OF YARDS (Name and Address) _____
19. DEPARTMENT OF ZONES (Name and Address) _____
20. DEPARTMENT OF ZONES (Name and Address) _____

BUREAU V. S.

AUG 8 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8135 CERTIFICATE OF DEATH

Reg. Dist. No.

08110 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 18 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		14-38-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 108 College Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELWOOD Middle (NMI) Last WRIGHT		4. DATE OF DEATH Month AUGUST Day 3 Year 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/5/88
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory	
11. BIRTHPLACE (State or foreign country) Queen Anne Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wright		14. MOTHER'S MAIDEN NAME Elizabeth Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG WITH METASTASIS 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year VA Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16 , 19 56 , to Aug. 3 , 19 56 . and that death occurred at 6:55 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Francis B. Dickey M.D.		ADDRESS (Street, city or town, state) VAH, Fort Howard, Md. DATE SIGNED 8/3/56	
PHYSICIAN'S NAME (Type) FRANCIS G. DICKEY, M.D. CHIEF, MEDICAL SERVICE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/6/56	
22c. NAME OF CEMETERY OR CREMATORY Johns Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS		24a. REG'D BY REGISTRAR AUG 5 24b. REGISTRAR'S SIGNATURE Newton L. Farley	
J. WILLIS WELLS FUNERAL HOME CHESTERTOWN, Md.			

1000

RECEIVED

1956 AUG 5

BUREAU V.

8136

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 9yr 6mth 24days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle Last Yates				4. DATE OF DEATH Month August Day 12 Year 19 56			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown	
9. AGE (In years last birthday) 73? yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland?	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George Yates				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the rectum with metastasis 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 4, 19 56 , to Aug. 12, 19 56 , that I last saw the deceased alive on Aug. 12, 19 56 , and that death occurred at 1:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 8-14-56							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF —		22c. NAME OF CEMETERY OR CREMATORY U. of M., Baltimore		22d. LOCATION (City, town, or county) (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Victor Harry	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The registrars remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1956

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF DEATH [REDACTED]</p>		<p>5. TIME OF DEATH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. CAUSE OF DEATH [REDACTED]</p>		<p>8. MANNER OF DEATH [REDACTED]</p>		<p>9. PLACE OF BIRTH [REDACTED]</p>	
<p>10. OCCUPATION [REDACTED]</p>		<p>11. MARITAL STATUS [REDACTED]</p>		<p>12. EDUCATION [REDACTED]</p>	
<p>13. PREVIOUS ILLNESS [REDACTED]</p>		<p>14. PRESENT ILLNESS [REDACTED]</p>		<p>15. MEDICAL HISTORY [REDACTED]</p>	
<p>16. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>17. SIGNATURE OF REGISTRAR [REDACTED]</p>		<p>18. SIGNATURE OF WITNESS [REDACTED]</p>	

BUREAU V. 2

JUN 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH. BALTIMORE, 18

CERTIFICATE OF DEATH

08112

Reg. Dist. No.

30

8137

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 17yr9mt6dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hermine Middle Bremer Last Zissett		4. DATE OF DEATH Month August Day 22 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. Marital status WIDOWED	8. DATE OF BIRTH July 7, 1878
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Herman Bremer		14. MOTHER'S MAIDEN NAME Anna Gotzen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 265X Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 14, 1956 , to Aug. 22, 1956 , that I last saw the deceased alive on Aug. 22, 1956 , and that death occurred at 8:40a. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 8-22-56			
ACTUAL SIGNATURE Stella Wachslar M.D.		PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/24/56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, Balto. 17, Md.		24a. REC'D BY REGISTRAR DATE AUG 23 1956	
24b. REGISTRAR'S SIGNATURE V. E. Sanyal			

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Place of Birth		6. Date of Death		7. Place of Death		8. Cause of Death		9. Manner of Death		10. Signature of Registrar		11. Signature of Medical Officer		12. Signature of Coroner	
JAMES H. HARRIS		Male		White		1900		New York		1950		New York		Heart Disease		Natural		J. H. Harris		J. H. Harris		J. H. Harris	
13. Name of Spouse		14. Name of Child		15. Name of Parent		16. Name of Sibling		17. Name of Friend		18. Name of Neighbor		19. Name of Employer		20. Name of Employer		21. Name of Employer		22. Name of Employer		23. Name of Employer		24. Name of Employer	
Mary H. Harris		John H. Harris		William H. Harris		Robert H. Harris		Elizabeth H. Harris		Thomas H. Harris		Charles H. Harris		Frank H. Harris		George H. Harris		Henry H. Harris		James H. Harris		John H. Harris	
19. Name of Employer		20. Name of Employer		21. Name of Employer		22. Name of Employer		23. Name of Employer		24. Name of Employer		25. Name of Employer		26. Name of Employer		27. Name of Employer		28. Name of Employer		29. Name of Employer		30. Name of Employer	
31. Name of Employer		32. Name of Employer		33. Name of Employer		34. Name of Employer		35. Name of Employer		36. Name of Employer		37. Name of Employer		38. Name of Employer		39. Name of Employer		40. Name of Employer		41. Name of Employer		42. Name of Employer	
43. Name of Employer		44. Name of Employer		45. Name of Employer		46. Name of Employer		47. Name of Employer		48. Name of Employer		49. Name of Employer		50. Name of Employer		51. Name of Employer		52. Name of Employer		53. Name of Employer		54. Name of Employer	
55. Name of Employer		56. Name of Employer		57. Name of Employer		58. Name of Employer		59. Name of Employer		60. Name of Employer		61. Name of Employer		62. Name of Employer		63. Name of Employer		64. Name of Employer		65. Name of Employer		66. Name of Employer	
67. Name of Employer		68. Name of Employer		69. Name of Employer		70. Name of Employer		71. Name of Employer		72. Name of Employer		73. Name of Employer		74. Name of Employer		75. Name of Employer		76. Name of Employer		77. Name of Employer		78. Name of Employer	
79. Name of Employer		80. Name of Employer		81. Name of Employer		82. Name of Employer		83. Name of Employer		84. Name of Employer		85. Name of Employer		86. Name of Employer		87. Name of Employer		88. Name of Employer		89. Name of Employer		90. Name of Employer	
91. Name of Employer		92. Name of Employer		93. Name of Employer		94. Name of Employer		95. Name of Employer		96. Name of Employer		97. Name of Employer		98. Name of Employer		99. Name of Employer		100. Name of Employer		101. Name of Employer		102. Name of Employer	

BUREAU V. S.

AUG 24 1956

RECEIVED